

**Evangelization, Injections, and the Baganda:  
Mengo Hospital and Biomedicine in Uganda**

James Henry Hammond

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Advised by Professor Nancy Rose Hunt

*For Mooney Hammond*

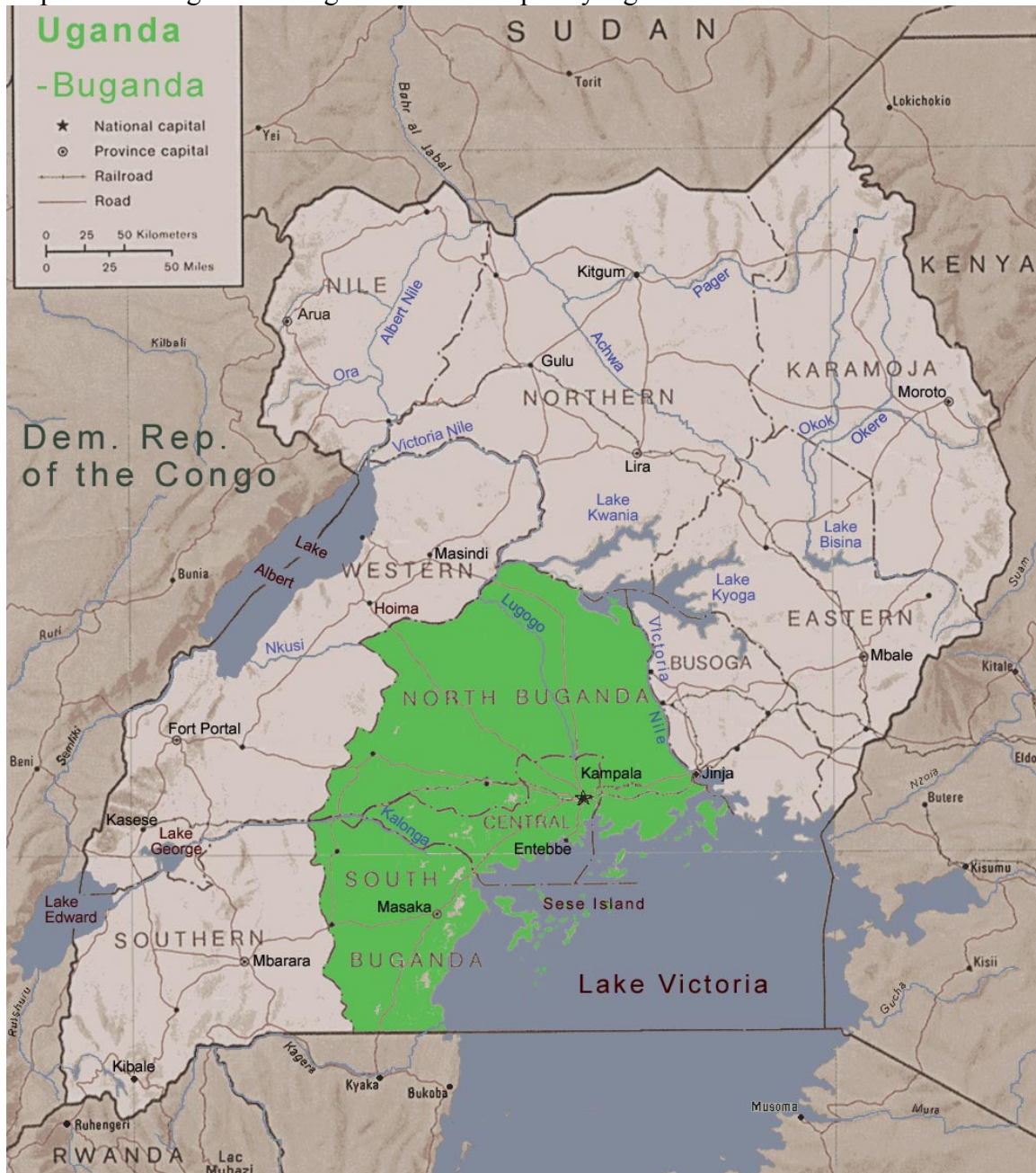
## TABLE OF CONTENTS

<b>Figures</b> .....	ii
<b>Acknowledgements</b> .....	iv
<b>Introduction</b> .....	1
<b>Chapter One: Admission</b> .....	19
<b>Chapter Two: Patients, Kin, and Society</b> .....	45
<b>Chapter Three: Treatment</b> .....	71
<b>Chapter Four: Training</b> .....	97
<b>Conclusion</b> .....	105
<b>Bibliography</b> .....	109

## FIGURES

### Map

Map 1: The Kingdom of Buganda in Contemporary Uganda<sup>1</sup>



<sup>1</sup> “Uganda—Buganda,” in “Uganda the Country and the People—Bantu tradition,” *Face Music*, [http://www.face-music.ch/inform/poeple\\_ugandabantu\\_en.html](http://www.face-music.ch/inform/poeple_ugandabantu_en.html) by Sarah Ndagire. (accessed March 28, 2012).

## **Tables**

Table 1: Mengo Hospital venereal disease statistics 1904-6	5
Table 2: Religious Affiliations of Mengo Hospital In-patients, 1908	26
Table 3: Religious Affiliations of Mengo Hospital In-patients, 1913	26
Table 4: “Runaway” patients from Mengo Hospital	75
Table 5: Percentage of Mengo Hospital Revenue from Arsenical Injections, 1921-1926	84

## **Images**

Image 1: Dr. Albert Ruskin Cook	1
Image 2: View of Mengo Hospital and Narirembe Cathedral	19
Image 3: Two “Native” assistants carrying Katharine Cook	22
Image 4: The First Mengo Hospital	32
Image 5: The Second Mengo Hospital	33
Image 6: The Third Mengo Hospital	35
Image 7: View of Kampala from Namirembe Hill, 1897	44
Image 8: Sick Patient Carried to Mengo Hospital	54
Image 9: Katharine Cook Dispensing Medicine while on Safari	70
Image 10: “Native” Medical Assistants Helping Perform an Operation	96

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## INTRODUCTION

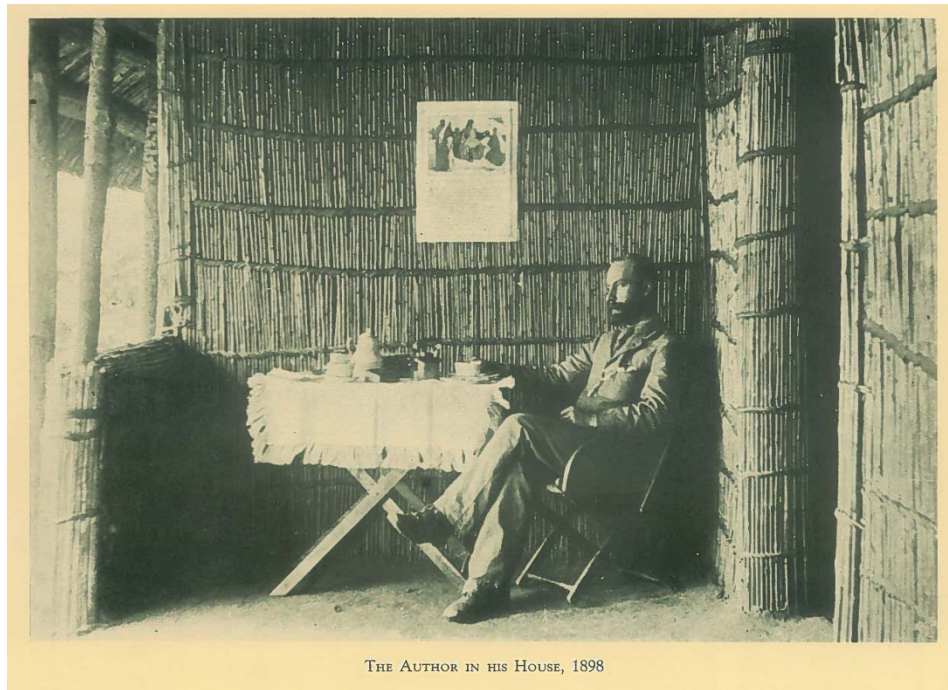


Image 1: Dr. Albert Ruskin Cook<sup>1</sup>

In Kampala, the capital of the Kingdom of Buganda, the longer rainy season would have been coming to a close on May 9, 1915.<sup>2</sup> Though the rainy seasons in Buganda were closely linked with the cultivation of bananas, limitations on state tyranny, and public healing,<sup>3</sup> Sibyalika, a young, “heathen” female Muganda sought medical attention outside the realm of traditional medicine. Instead she came to Mengo Hospital, a Church Mission Society (CMS) missionary hospital founded by Dr. Albert Cook and his wife, Katharine Timpson Cook. The Mengo case notes do not reflect who accompanied her, but Sibyalika

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<sup>1</sup> “The Author in His House, 1898,” in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 34.

<sup>2</sup> “Buganda” refers to a geographical location and state. “Baganda” refers to a people. A “Muganda” is a single male or female Baganda. “Luganda” is the language of the Baganda. “Ganda” is an adjective.

<sup>3</sup> Neil Kodesh has shown that there was an intimate relationship between the Buganda’s two rainy seasons, banana cultivation, public healing rituals, and limiting state tyranny. Neil Kodesh, *Beyond the Royal Gaze: Clanship and Public Healing in Buganda* (University of Virginia, 2010), 88-97.



brought with her a letter, notifying Cook that two weeks earlier Sibyalika had been raped. A week after the rape, ulcers erupted on her vulva.

Thus, a week after the sores erupted, Sibyalika came face-to-face with Dr. Cook inside the brick walls of Mengo Hospital. A female nurse examined her. In Sibyalika's case note, it was recorded that her vulva was swollen, her labia majoria and vulva were ulcerated, her ankle also bore a sore, and her whole body was covered in a "scaly eruption." It appears that Cook took a particular interest in Sibyalika's case. He wrote in the margins of her case notes, "Age 12. Has not yet menstruated," although doctors at Mengo Hospital did not normally note their African patients' ages.<sup>4</sup>

Cook diagnosed Sibyalika with syphilis, after which either female European nurses, or male Baganda assistants, would have directed her to the Roosevelt Block, a section of the Hospital dedicated to isolating "native"—the term the British used to refer to their African subjects—patients with venereal disease. Cook prescribed a syphilis treatment regimen: a mercury ointment applied to the groin, and intramuscular mercury injections. Such mercury treatment, though highly toxic, was Cook's standard treatment, and likely the most readily available treatment for syphilis in Uganda, in 1915. However, Sibyalika reacted poorly to the mercury ointment. When her vulva had swollen to twice its normal size, six days after treatment began, Cook stopped the mercury ointment treatment.

Four days later, on May 19, Sibyalika showed more alarming signs. Her mouth began to ache, indicative of mercury poisoning. Cook stopped the mercury injections as well. Sibyalika's condition, however, continued to deteriorate. On May 22, she started salivating excessively, a symptom of acute mercury poisoning that often presaged death.

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<sup>4</sup> Mengo Hospital In-Patient case notes, 1915, Albert Cook Library, Mulago Medical School, Makerere University, Uganda (hereafter referred to as ACML), 940. Sibyalika admitted May 9, 1915.

Sibayalika, however, did not succumb to mercury's toxicity. Instead, on July 10, 1915, she was discharged, and Cook declared her to be "cured."<sup>5</sup> By then the dry season would have been in full swing, with lush, dense vegetation covering the area around Lake Victoria. During those two months, Sibayalika had been treated both with Western medicine and with daily Christian sermons.

How should Sibayalika's sojourn at Mengo – her rape, infection with venereal disease, and complications arising in treatment – be interpreted? To missionary figures Sibayalika's rape and infection would have spoken of "native savagery," and moral degeneracy, and, ultimately, would have reinforced their conviction that God and biomedicine must be brought to the "dark continent." If Frantz Fanon's writings on biomedicine in colonial Algeria could be applied to Sibayalika's case, Sibayalika and her kin would have perceived her clinical encounter as a contest with a colonizing power: "When the colonized escapes the doctor, and the integrity of his body is preserved, he considers himself the victor by a handsome margin. For the native the visit is always an ordeal."<sup>6</sup> Both medical missionary moralizing, and "native" resistance found their way into syphilis treatment and experience in Uganda, but in the long term the significance of syphilis treatment in Uganda would be that it signaled the beginning of the Baganda incorporating and adapting biomedical systems of knowledge into their own narratives of disease.

### **Historical Background**

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<sup>5</sup> Ibid.

<sup>6</sup> Frantz Fanon, *A Dying Colonialism*, trans. Haakan Chavalier (New York: Monthly Review Press, 1965), 127-8.

In 1894, the British created the British Protectorate of Uganda, an amalgamation of pre-colonial kingdoms and peoples that included the Kingdom of Buganda.<sup>7</sup> Colonial officials were determined to make the infant protectorate showcase the benefits of British colonialism in the heart of Africa.

However, as elsewhere in Africa where colonial forces uprooted traditions of public healing and disrupted ecological patterns, epidemics emerged, and birthrates plummeted.<sup>8</sup> As the British took possession of their new Protectorate, an epidemic of trypanosomiasis, sleeping sickness, swept the countryside, claiming 250,000 to 330,000 lives between 1900 and 1925.<sup>9</sup> By 1905, the two-pronged British response, of coercive measures against the population, including quarantine, eviction, regulation of mobility throughout the Protectorate, and of environmental measures, such as burning away bush, appeared to have paid off.<sup>10</sup> Sleeping Sickness incidence dropped significantly.

Nonetheless, Uganda's "native" population seemed to continue to dwindle.<sup>11</sup> Colonial officials then identified a new biological threat: venereal disease, particularly syphilis. In 1908, responding to Governor Hesketh Bell's call to investigate the prevalence of syphilis, the British Government sent Francis Lambkin, a Colonel in the Royal Army Medical Corps (RAMC) and a venereal disease specialist, to the Protectorate. Lambkin's

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<sup>7</sup> Michael William Tuck, "Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda" (PhD diss., Northwestern University, 1997), 34.

<sup>8</sup> Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no.2/3 (June-September, 1985): 73-147; Leroy Vail, "Ecology and History: the Example of Eastern Zambia," *Journal of Southern African Studies* 3, no. 3 (April, 1977) 129-155; Rita Headrick, *Colonialism, Health and Illness in French Colonial Africa, 1885-1935* (Atlanta, Georgia: African Studies Association Press, 1994).

<sup>9</sup> Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," *Signs* 16, no. 4 (Summer, 1991).

<sup>10</sup> Ibid; A.D.P. Hodges, *Appendix to the Annual Medical Report 1908: Sleeping Sickness in the Uganda Protectorate during 1908* (Entebbe: Government Printer, 1909), 1.

<sup>11</sup> Shane Doyle, "Population Decline and Delayed Recovery In Bunyoro," *Journal of African History* 41, no. 3 (London; New York: Cambridge University Press, 2000): 441-446. This article, while focusing on the Bunyoro's severe population decline and delayed recovery, but all three major Kingdoms in the Great Lakes Region, Bunyoro, Buganda, and Buhaya, all experienced population declines during the colonial era.

investigation asserted that syphilis had “gained a firm footing in the Protectorate, and, being left to itself, caused devastation everywhere among the inhabitants.”<sup>12</sup>

Uganda’s European medical establishment accepted and expanded on Lambkin’s findings. Lt. Col. Aubrey Hodges, Uganda’s Principal Medical Officer (PMO) from 1908-1918, agreed with Lambkin, reporting to the Protectorate Government “no doubt the birth rate and the infantile mortality rate are materially affected by the prevalence of syphilis and other venereal disease.”<sup>13</sup> Newspaper contributors wrote: “[t]he greatest human scourge in East Africa is not Leprosy, Plague, or Sleeping Sickness but an older disease and one more insinuating and deadly in its dissemination among our people, namely the Venereal.”<sup>14</sup> Likewise, Albert Cook, the most prominent missionary physician in Uganda, undoubtedly agreed with Lambkin, as he provided the statistics Lambkin relied on to prove that Uganda suffered from an epidemic of syphilis. Cook revealed to Lambkin that venereal disease accounted for a significant portion of his in-patients:

Table 1: Mengo Hospital venereal disease statistics 1904-6<sup>15</sup>

<i>Year</i>	<i>Total In-Patients</i>	<i>Total Venereal Patients</i>	<i>% Venereal Patients</i>	<i>Total Syphilis Patients</i>	<i>% Syphilis Patients</i>
1904	1,021	209	20.45%	140	13.71%
1905	1,379	252	18.27%	152	11.02%
1906	1,768	326	18.43%	204	11.54%

Cook also told Lambkin that in the period from 1904 through 1906, 13,000 outpatients, or 22% of the total, were found to have venereal disease.<sup>16</sup> Cook’s estimation of the reach of

<sup>12</sup> F.J. Lambkin, “An Outbreak of Syphilis on Virgin Soil,” in *A System of Syphilis*, ed. D’Arcy Power (London: Oxford University Press, 1908), 2: 339.

<sup>13</sup> A.D.P. Hodges, *Annual Report by the Principal Medical Officer, Uganda Protectorate* (Entebbe: Government Printer, 1909), 14.

<sup>14</sup> “The Irony of the Comparison,” *The East African Standard*, February 22, 1908.

<sup>15</sup> A.R. Cook to F.J. Lambkin, December 14, 1907, in box: “Incoming General Correspondence 1899, 1902-9,” ACML.

<sup>16</sup> *Ibid*

syphilis in the Kingdom of Buganda would grow with time. In 1929, during the interwar era between 1918-1939, Cook claimed that while only 20% of the population showed active signs of syphilis infection, 80% of the Baganda were serologically positive based on Wasserman testing.<sup>17</sup> In 1937, he declared to the CMS: “[s]yphilis is rampant; indeed it is calculated that eighty per cent of the population [of the Baganda] have had it in one form or another.”<sup>18</sup>

Thanks in part to Cook’s insistence on the pervasiveness of syphilis, the disease became the Protectorate’s principal health concern. Colonial officials singled out syphilis as the primary barrier to Uganda’s development and economic viability. In 1919, Governor Coryndon called together the Protectorate’s most influential chiefs and colonial officials to discuss a number of matters, the most important of which he identified as venereal disease.<sup>19</sup> In 1920, the Uganda Development Commission repeated what colonial officials and missionaries had been declaring for years: syphilis was responsible for the death rate outpacing the birthrate in Uganda.<sup>20</sup> The East Africa Commission of 1925, reporting to the British Parliament, concurred:

Looking to the future of Uganda... with its vast unoccupied area capable of still further cultivation, the problem of population is a serious one. ...There can be no doubt whatever that the principal cause of this decline [in population] has been venereal.<sup>21</sup>

Thus, colonial officials feared that syphilis would keep Uganda from becoming more profitable. In this perception of the impact of syphilis, the colonial authorities mirrored the

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<sup>17</sup> A.R. Cook, *The Treatment of Ante-Natal Syphilis in Buganda Women*, delivered to the Uganda Branch of the British Medical Association (hereafter referred to as the UBBMA) on March 22, 1929.

<sup>18</sup> A.R. Cook, “Report of the CMS Mengo Hospital, 1897-1937,” 8.

<sup>19</sup> “The Governor Meets Native Chiefs: Many Important Topics Discussed,” *The Uganda Herald*, September 26, 1919.

<sup>20</sup> Uganda Development Commission, “VI Public Health and Sanitation: Venereal Disease” *The Uganda Herald*, April 2, 1920.

<sup>21</sup> Secretary of State to the Colonies. *Report of the East Africa Commission*. 1925 Cmd. 2387, 144.

British view that venereal disease sapped a man's virility, and projected it upon the Protectorate.<sup>22</sup>

Furthermore, colonial officials thought that the syphilis epidemic revealed immorality festering in "native" populations, in particular the Baganda, since colonial interventions had uprooted them from "traditional" mores. When Lambkin announced the syphilis epidemic, he blamed Ganda "moral degradation" on: "1. The introduction of Christianity. 2. The abolition of the punishments formerly meted out among the tribes for all immoral offences committed by either sex."<sup>23</sup> In his opinion, Christianity had liberated African women from oppressive patriarchal systems that had kept their sexual urges in check, leading to a profusion of sexual immorality and the inevitable spread of venereal disease.<sup>24</sup> Having announced the syphilis epidemic, Lambkin then organized the Protectorate government's response, setting up a mass vaccination campaign that faltered with the onset of the First World War. After the Great War, the Protectorate renewed its anti-venereal efforts in Uganda, this time under the leadership of George Keane, who used Mulago Hospital as his base of operations, and collaborated more successfully than Lambkin with the missionary efforts at the CMS's Mengo Hospital.<sup>25</sup>

While the CMS agreed with Lambkin that immorality was at the root of the outbreak, not surprisingly they proposed that it was land reforms, not Christianity, that had disrupted the Ganda moral universe. Alfred Tucker, the Bishop of Uganda, wrote in response to Lambkin: "With this sweeping away of the feudal system has come in not liberty merely but

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<sup>22</sup> Mary Wilson Carpenter, *Health, Medicine, and Society in Victorian England* (Westport, CT: Praeger, 2010), 71-91.

<sup>23</sup> F.J. Lambkin, "An Outbreak of Syphilis on Virgin Soil," in *A System of Syphilis*, ed. D'Arcy Power (London: Oxford University Press, 1908), 2: 344.

<sup>24</sup> *Ibid.*, 339-357.

<sup>25</sup> Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," *Signs* 16, no. 4 (Summer, 1991): 787-807.

license, and the result we have stated for us in Colonel Lambkin's paper. Christianity, in my opinion, has had nothing whatever to do with these lamentable consequences."<sup>26</sup> Cook agreed with Tucker, and went further, asserting with some self-righteous indignation that: "Christianity from the beginning has acted as a deterring and restraining force and is indeed, when intelligently accepted, the only true prophylaxis to this terrible scourge."<sup>27</sup> Thus in Cook's view, Mengo Hospital, as a missionary hospital, was uniquely situated to combat both the disease, and the underlying immorality that fostered its spread.<sup>28</sup>

### **Historiography**

Scholars have already devoted considerable attention to syphilis and maternity care in colonial East Africa, and at Mengo Hospital itself, as well as to the efforts of medical missionaries. Previous historical work on Mengo Hospital and syphilis in Uganda, particularly that of Vaughan, has employed theories on disease as a social construct. In this thesis, I reevaluate the Uganda syphilis epidemic in the light of more recent scholarship on medical missionary evangelical and clinical work. In so doing, I show that beyond a social construct, syphilis treatment at Mengo Hospital played an integral role in the process by which the Baganda disputed, negotiated the role of, and ultimately adopted their version of biomedical care.<sup>29</sup>

Medical historians and anthropologists began thinking about syphilis in Uganda as a social construct when Davies and Orley both argued that the so-called "epidemic of 1897"

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<sup>26</sup> Alfred R. Tucker, "Syphilis in Uganda." *The Lancet*, October 24, 1908.

<sup>27</sup> Albert R. Cook, "Syphilis in Uganda." *The Lancet*, December 12, 1908.

<sup>28</sup> Catholic missionaries also founded hospitals. The French-speaking White Father missionaries founded Rubaga Hospital in 1899, and Catholic Franciscan Sisters founded Nsambya Hospital in 1906. Mengo Hospital, however, remained the preeminent missionary hospital through the 1920s. Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 247.

<sup>29</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford University Press, 1991), 129-52.

confused syphilis with yaws, another treponemal disease almost indistinguishable from syphilis in its clinical presentation.<sup>30</sup> Orley argued that the Baganda and Nyoro employed sophisticated vaccination techniques for yaws, making it more probable that the “outbreak” of syphilis was actually endemic yaws.<sup>31</sup> In the 1950s, J.N.P. Davies, while a Pathology Professor at Makerere Medical School in Uganda, wrote:

He [Cook] also became convinced that an epidemic of syphilis was in progress, but of this there is little real evidence. It is not supported by his own figures; it is not in consonance with other evidence; and it seems on many grounds inherently improbable.<sup>32</sup>

In Davies’ opinion, Lambkin and Cook confused endemic yaws with an epidemic of syphilis. However, Davies also argued that venereal syphilis gradually displaced yaws in the population, leading to a true epidemic of syphilis in Uganda.

Megan Vaughan seized upon Davies’ and Orley’s arguments to posit that the syphilis epidemic in Uganda served colonial ends. Vaughan shows that while symptomatically similar to syphilis, yaws is associated with poverty, not sexuality, and, therefore, a yaws epidemic has a profoundly different social meaning from a syphilis epidemic.<sup>33</sup> Vaughan maintained that the creation of an imaginary syphilis epidemic was instrumental in constructing “the African” as a colonial subject. She argued that syphilis shaped British

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<sup>30</sup> Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 10.

<sup>31</sup> John Orley, “Concepts of Infectious Disease amongst the rural Ganda- with special reference to yaws and syphilis,” in *Nkanga: Special edition on Medicine and Social Sciences in East and West Africa*, ed. F.J. Bennett (Kampala: Makerere Institute of Social Research, 1973), 60-6; John Orley, “Indigenous Concepts of Disease and their Interactions with Scientific Medicine,” in *Health in Tropical Africa during the Colonial Period* eds. E.E. Saben-Clare, D.J. Bradley and K.K. Kirkwood (Oxford, 1980), 127-37

<sup>32</sup> J.N.P. Davies, “The History of Syphilis in Uganda,” *Bulletin of the World Health Organization* 15 (1956): 1049.

<sup>33</sup> Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford University Press, 1991), 129-52; Megan Vaughan, “Syphilis in East and Central Africa,” in *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* eds. Terence Ranger and Paul Slack (Cambridge University Press, 1992), 269-302; Megan Vaughan, “Health and hegemony: representation of disease and the creation of the colonial subject in Nyasaland,” in *Contesting Colonial Hegemony: State and Society in Africa and India* eds. Dagmar Engels and Shula Marks (London: British Academic Press, 1994) 172-201.



conceptions of African sexuality as simultaneously “primitive,” “wild,” “uncontrolled,” and “innocent.” According to Vaughan, the construction of the syphilis epidemic simultaneously pathologized African sexuality, demonstrated the necessity of European intervention, and thereby, neatly justified British indirect rule.<sup>34</sup>

Other scholars have built on syphilis as a social construction in Uganda. Summers traced the development of the notion among colonial officials and missionaries that syphilis was not simply a medical condition, but a moral one. She showed a sea change in the colonial discourse during the interwar era, arguing that after the Great War, missionary efforts co-opted the colonial administration’s prior technical approach to the treatment of syphilis.<sup>35</sup> In my view, Summers’ argument over-simplifies a complex topic. While she correctly identifies a real shift in colonial policy during this period, she ignores that syphilis and its treatment in Uganda always had social, political, and religious dimensions.

Tuck expanded on Vaughan’s work. In his dissertation, he examined Ganda conceptions of sickness, health, and the vernacular term, *kabotongo*, which embraced the two easily confused treponemal diseases syphilis and yaws. Additionally, he illustrated how the Baganda male elite made use of the social construction of syphilis to enlarge its authority over women during a period when colonial social dynamics challenged this group’s control over social reproduction.<sup>36</sup> Tuck, thus, showed that the syphilis epidemic served as a tool of social control, not only for the colonizers, but also for chiefs and emerging literate elites, that enabled, to the benefit of both groups, the British system of indirect rule.

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<sup>34</sup> Ibid.

<sup>35</sup> Carol Summers, “Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925,” *Signs* 16, no. 4 (Summer, 1991).

<sup>36</sup> Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997).

Other scholarship, while acknowledging the role of the disease as a social construct, has emphasized economic incentives for treating syphilis and perpetuating the notion of an outbreak. Kuhanen agrees with Vaughan and Tuck that syphilis was a tool for social control, but argues that economic motivations underlay both missionary and government interest in and concern about the epidemic.<sup>37</sup>

However, more recent scholarship has begun to look beyond the role of syphilis in Uganda as a social construct. In his book, *East African Doctors: A History of the Modern Profession*, John Iliffe briefly hints at the immense importance of syphilis in the creation of an African medical profession in Uganda. He relates how in 1913, during the First World War, George Keane, the Uganda Protectorate's venereal disease specialist, "was impressed by Mengo Hospital's African staff, and decided to train his own African assistants [to deal with the syphilis epidemic.]"<sup>38</sup> However, Iliffe provides no further analysis of how anti-venereal efforts integrated Africans into a biomedical system by, for example, popularizing biomedical treatments among patients, as well as inspiring education of male Baganda medical assistants and development of an extensive midwifery school.

In part taking the lead from Iliffe's brief analysis of syphilis in Uganda, in this thesis, rather than looking at how medical officials and missionaries used syphilis to "pathologize" the African, I reassess the Uganda syphilis epidemic as part of an evangelical program to "colonize the consciousness," and seek to examine how the Baganda responded to this effort. Frantz Fanon's work is often cited as an illustration of how Africans perceived colonial medical efforts. Fanon argued: "Introduced into Algeria at the same time as racialism and

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<sup>37</sup> Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 287-306.

<sup>38</sup> John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge, Cambridge University Press, 1998), 33.

humiliation, Western medical science, being part of the oppressive system, has always provoked in the native an ambivalent attitude.”<sup>39</sup> Fanon claimed that European doctors comprised part of a colonial agenda, and thus, that interactions between African patients and white doctors always contained an element of the competition between “colonizer” and “colonized.”<sup>40</sup> Mengo Hospital’s case notes reveal the ambiguity Fanon described, but the missionaries at Mengo, while aligned with the colonial state’s interests, also pursued distinct objectives and engaged in a distinct, more individualized, medical practice to accomplish those goals.

Jean and John Comaroff argue that, unlike colonial biopolitical states, missionaries were concerned with evangelization and the “colonization of consciousness.”<sup>41</sup> They maintain that “in the domain of implicit signs and practices, of the diffuse control over everyday meaning,” Christian evangelists “instilled the authoritative imprint of Western capitalist culture.”<sup>42</sup> According to the Comaroffs the medical mission clinic composed a tactile healing frontier in the missionary civilizing mission “where feelings of recognition, even compassion, flowed across the cleavages of a racially divided society.”<sup>43</sup> The Comaroff’s claims have been disputed. J.D.Y. Peel, for one, countered with the example of the Yoruba Christians, arguing that the Yoruba actively appropriated Christian doctrine,

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<sup>39</sup> Frantz Fanon, *A Dying Colonialism*, trans. Haakan Chavalier (New York: Monthly Review Press, 1965), 121.

<sup>40</sup> *Ibid.*, 121-131.

<sup>41</sup> Jean and John L. Comaroff, “The colonization of consciousness in South Africa,” *Economy and Society* 18, no. 3 (August, 1989): 267; John Parker and Richard Rathbone, *African History: A Very Short Introduction* (Oxford: Oxford University Press, 2007), 77.

<sup>42</sup> Jean and John L. Comaroff, “Christianity and colonialism in South Africa,” *American Ethnologist* 1, no.13 (February, 1986): 1-22.

<sup>43</sup> Jean and John L. Comaroff, “The Medicine of God’s Word: Saving the Soul by Tending the Flesh,” *Of Revelation and Revolution: the dialectics of modernity on a South African Frontier* (Chicago: University of Chicago Press, 1997), 323-3.

fashioning it into something uniquely Yoruba.<sup>44</sup> In more recent work, specifically on medical missionaries in Africa and Asia, David Hardiman and his contributing authors show that: “A more lasting legacy of medical missions most probably lay not so much in the number of converts they won, but in their popularisation [sic] of biomedicine.”<sup>45</sup> Using Hardiman’s thesis as a frame for my argument, I examine how an imagined epidemic that, for Europeans, differentiated and stigmatized the “African,” also triggered, for the Baganda, appropriation of biomedical practices and the creation of an African biomedical profession.

The literature reviewed here falls into two broad categories: the work Vaughan pioneered on the Ugandan syphilis outbreak and the construction of colonial African subjects, and research on the institutional clinic as a locale for the negotiation between colonial and “native” systems of care. I seek to merge these two, interrelated, streams of scholarly work in my analysis of medical practices at Mengo Hospital.

### **Methodology—Case Notes**

I conducted the bulk of my primary motivation research in the Albert Cook Library at Mulago Medical School in Kampala, Uganda. The Albert Cook Library houses Albert Cook’s personal archive: the Mengo Hospital Papers, including meeting minutes, Mengo Hospital correspondence dating from 1899 to 1944, copies of the CMS’s *Mercy and Truth*, proposed syllabi for medical and nursing students, reports, lecture drafts, ledgers, and hospital case notes for both European and African patients.

The cases notes were the primary source for my research in Uganda. However, upon arriving in Kampala, I discovered that analyzing the cases notes posed considerable potential

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<sup>44</sup> John Parker and Richard Rathbone, *African History: A Very Short Introduction* (Oxford: Oxford University Press, 2007), 77.

<sup>45</sup> David Hardiman, introduction to *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam: Rodopi, 2006), 48.

challenges. First, it would take significantly more time than I had in Uganda to read and transcribe the roughly 150 volumes of case notes. Furthermore, the notes are replete with idiosyncratic orthography and shorthand, and early 20<sup>th</sup> Century Britishisms and medical jargon. In addition, they generally omit significant patient information, such as age, gender, and ethnicity. As a result, decoding and understanding the notes required imaginative investigative work.

The archive also contains much of Mengo Hospital's incoming correspondence from CMS headquarters in London, from colonial officials in Uganda, and from Cook's family. I surmised that Cook's correspondence would yield information more readily subject to historical analysis. Therefore, I initially mined Mengo Hospital's correspondence for evidence of Christian missionary attitudes towards the syphilis epidemic and their evangelical work in Uganda before turning to the case notes.

Since there was not time to examine all the case notes or to conduct a systematic sampling, during my limited time in Kampala, I selectively chose case notes that supported or contradicted arguments in the secondary source literature, as well as told compelling stories. As a result, the case notes I examined in detail do not represent all cases of syphilis treated at Mengo Hospital. My sample is composed of 34 cases with 31 African, 3 European, and no Indian subcontinent, patients.

Additionally, it is inherent in the material, which was produced and selected by medical missionaries, that it does not directly provide the Ganda interpretation of the clinical encounter.<sup>46</sup> Beyond that, the case notes were made for the Hospital's medical and evangelical purposes, not historical study. They present a necessarily narrow view of the

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<sup>46</sup> Anna Laura Stoler, *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense* (Princeton and Oxford: Princeton University Press, 2009), 1-15.

medical experience, focusing on the patient's body, rather than on the subjective interpretations of the patient, or the broader social dynamic that mediated medical care. Moreover, the information provided by patients cannot be taken at face value, since, as Fanon illustrates, African patients often perceived European biomedical practitioners as extensions of the state, and did not always trust them.<sup>47</sup>

To fill in the gaps in the case notes, and my own understanding of missionary medical care in Africa, I turned to Albert Cook's memoir, *Uganda Memories*, and to newspaper articles, some of them written by the Cooks, on the CMS's medical efforts in Uganda. I also looked to secondary source material on medical missionary efforts in Uganda. Luise White ambitiously confronts, expands on, and grapples with, the multiplicity of meaning ascribed to medical practice at Mengo Hospital and elsewhere in East Africa. Drawing on oral traditions and rumors, she reevaluates missionary narratives of how Africans interpreted medical dispensaries, anesthesia, and injections.<sup>48</sup> White's argument accesses oral sources and rumor in African history, and convincingly illustrates the divide between Baganda patients' and medical missionaries' narrative of medical treatment.

In my research on the experience of the Uganda missionary clinic, I have also looked to scholarly work from outside the discipline of history, as well as beyond my work's geographic and temporal borders. These scholarly works have encouraged me to consider the role of kin "therapy management groups," missionary medical efforts in Africa, the racialization of care, the "social life of things," and the interaction between biomedical and

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<sup>47</sup> Frantz Fanon, *A Dying Colonialism*, trans. Haakan Chavalier (New York: Monthly Review Press, 1965); Megan Vaughan, "Health and hegemony: representation of disease and the creation of the colonial subject in Nyasaland," in *Contesting Colonial Hegemony: State and Society in Africa and India* eds. Dagmar Engels and Shula Marks (London: British Academic Press, 1994), 173-201.

<sup>48</sup> Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley, Los Angeles, and London: University of California Press, 2000), 89-121; Luise White, "'They Could Make Their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda," *The American Historical Review* 100, no. 5 (December, 1995): 1379-1402.

indigenous systems of knowledge. Headrick in her work on French Equatorial Africa elegantly illustrates the intimate interaction between kin “therapy management groups” and missionary doctors at Albert Schweitzer’s clinic in Gabon.<sup>49</sup> Dirar, in an investigation of Capuchin priests in colonial Eritrea, reveals how they integrated and synthesized missionary medicine into indigenous medical systems.<sup>50</sup> Langwick illustrates how biomedical and traditional systems of health interact with each other in “Articulate(d) Bodies: Traditional medicine in a Tanzanian hospital,” an account of clinical work in Tanzanian Hospitals from the late 1990s to the 2000s. She argues: “Hospital practitioners in East Africa see traditional and modern medicine interrupt and interfere with one another on hospital grounds every day.”<sup>51</sup> Hunt also notably illustrates the interactions and border work between modern and traditional, colonial and indigenous, systems of care in her study of British Baptist missionary clinics in the Yakusu region of the Belgian Congo. Hunt asserts that:

Maternity hospitals and clinics were—and remain—sites of debate and negotiation, translation and mistranslation, in Africa. Men and women challenged and transfigured the health care that they received through complex social processes of struggle, bargaining and compromise.<sup>52</sup>

Hunt’s argument promotes a dynamic understanding of the experience, contestation, and interpretation of the colonial medicalization of reproduction. Like Langwick, she investigates the border work that colonial intermediary figures, particularly male African nurses, performed. Hunt also makes contributions in the use of objects and the “social life of things” as analytical tools to shed light on human emotions and experiences. Finally, she

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<sup>49</sup> Rita Headrick, *Colonialism, Health, and Illness in French Equatorial Africa 1885-1935* (Atlanta: African Studies Association Press, 1994).

<sup>50</sup> Uoldelul Chelati Dirar, “Curing Bodies to Rescue Souls: Health in Capuchin’s Missionary Strategy in Eritrea,” in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* ed. David Hardiman (Amsterdam: Rodopi, 2006), 251-280.

<sup>51</sup> Stacey Langwick, “Articulate(d) bodies: Traditional medicine in a Tanzanian hospital,” *American Ethnologist* 35, no. 3 (2008): 428.

<sup>52</sup> Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, NC: Duke University Press, 1999), 8.

examines a topic that most others have been silent on: European patients. She shows how the introduction of white women, particularly unmarried white women, to African colonies necessitated the creation of new colonial spaces between “native” and European.<sup>53</sup> I draw from all of these works in my interpretation of the dynamic construction of meaning in the missionary clinical setting at Mengo.

While I relied on the secondary literature to help define a framework for my interpretation, it was the stories in the Mengo Hospital case notes that compelled me to analyze the practice of evangelization and medicine at Mengo Hospital. The stories of Mengo patients vividly portray how syphilis presented itself in the flesh—in real people’s lives, and causing real anguish. In this way, the case notes humanize technical medical definitions and descriptions, and make the experience of these human beings matter intensely to a reader one hundred years later. They also deepen appreciation of the patients’ ambivalence regarding Mengo Hospital, and underline what may have driven Baganda patients to seek treatment there.

### **Argument**

Let us now return to Sibyalika’s case. If we treat her case as an “event,” it forms part of a series of narratives and historical arcs.<sup>54</sup> On one level, Sibyalika’s case is a linear narrative, from the sexual violation of a premenstrual child, through an arduous course of treatment with poisonous substances, to the declaration that she had been “cured.” However, her story also operates on additional, interrelated, levels of meaning. In this way, it is also a

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<sup>53</sup> Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, NC: Duke University Press, 1999); Nancy Rose Hunt, “‘Le Bebe en Brousse’: European Women African Birth Spacing and Colonial Intervention in Breast Feeding in Belgian Congo,” *The International Journal of African Historical Studies* 21, no. 3 (1988): 401-432.

<sup>54</sup> Reinhart Koselleck, *Futures Past: On the Semantics of Historical Time* trans. Keith Tribe (New York: Columbia University Press, 2004), 105-114.



story that reinforces a colonial conception of African sexuality as brutal, wild, innocent, and diseased; a story of colonial power exerted on the “native” through missionary medical intervention on African bodies, and missionary efforts to inculcate “native” minds with British sexual mores; and a story of African entry into European spaces, and African “appropriation” of European medicines and medical forms that suggests, without directly revealing, how “natives” constructed meaning of the care received there. Most importantly, therefore, it is part of the story of human interaction within the colonial world and the concomitant construction of knowledge. In these ways, Sibyalika’s case, though distinct, speaks to broader experiences within the hospital milieu, in which the Baganda, both as patients and medical intermediates, became increasingly involved with the practice of biomedicine.

Likewise, in this thesis, I argue that although Protestant missionary medical professionals tried to use syphilis in Uganda as a means for evangelization, and the Baganda continued to look to “traditional” methods of healing, and to resist biomedicine, syphilis treatment at Mengo Hospital became an interface for the Baganda to appropriate and negotiate the use of biomedical practices.

## CHAPTER ONE: ADMISSION



Image 2: View of Mengo Hospital and Narirembe Cathedral<sup>1</sup>

On Boxing Day, 1921, Zulula Lulyatumanyi left the swelling town of Kampala to walk uphill toward Narirembe Cathedral. Below the domed roof Cathedral, she could see the green, corrugated iron roofs of Mengo Hospital breaking through the foliage of the large forest trees. Her kin would most likely have accompanied this pregnant mother. When she arrived at the Hospital grounds, she would have gone first to the dispensary. There she would have waited in a large group, the men divided from the women, listening to a half-hour sermon.<sup>2</sup> Finally, when the sermon was over, she entered the consulting room, where the white doctor, Albert Cook, speaking in Luganda, asked the reason for her visit. Three weeks earlier Lulyatumanyi had noticed sores on her vulva and a general rash. Based on

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<sup>1</sup> “Mengo Hospital and Cathedral from Rubaga Hill,” in *Uganda Memories, 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 358.

<sup>2</sup> Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 210.

their conversation, Cook wrote in her case notes: “Gon[orrhoea] denied. One previous child—now grown up; no miscarriages. Husband had syph[ilis].”<sup>3</sup> Thereafter, Cook or a female nurse would have performed a genital examination, confirming that Lulyatumanyi had sores on her vulva.<sup>4</sup> From this history and examination, Cook diagnosed syphilis. Lulyatumanyi was then transferred to the Beatrice Ward, a female ward in the Hospital’s Roosevelt Isolation Block for “native” patients with venereal and infectious disease.<sup>5</sup> Walking towards the Beatrice Ward, she would have seen neatly cut grass lawns and magnolia bushes surrounding raised brick porches. She might have seen patients leaning against the bleached white walls, or have peered through windows with wooden shutters at patients in European style beds—white sheets and iron frames—all in neat rows. She would have been assigned to one such bed for the duration of her visit.<sup>6</sup>

The Europeans Lulyatumanyi encountered, the biomedical intake ritual she underwent, and the buildings she saw and walked between, were all part of a medical mission. Scholars have examined how medical missionaries aimed to inculcate in Africans European cultural attitudes, that is, to “colonize the consciousness.” Thus, focusing on South Africa, Jean and John Comaroff argue that:

in order to grasp how new hegemonies were laid down amidst local resistance, it is necessary to distinguish two levels of operation in colonizing cultures.

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<sup>3</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, Albert Cook Library, Mulago Medical School, Makerere University, Uganda (hereafter referred to as ACML), 2194. Zulula Lulyatumanyi admitted December 26, 1921.

<sup>4</sup> Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 268; Minutes, November, 1908, “Medical Subconference Meeting Minutes,” 1908-1925 (A.R. Cook Secretary), ACML; Minutes, September 7, 1922, “Recommendations to Central Midwives Board from CMS Medical Subconference concerning External or District Midwives,” 1908-1925 (A.R. Cook Secretary), ACML. The Medical Subconference was comprised of Rev. J Roscoe, and doctors Albert Cook, Jack Cook, and Bond.

<sup>5</sup> Former US President, Theodore Roosevelt opened the isolation ward while touring Uganda.

<sup>6</sup> Ibid.; “The Third Mengo Hospital; Men’s Block, 1904,” in *Uganda Memories, 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 202; “Mengo Hospital and Cathedral from Rubaga Hill,” in *Uganda Memories, 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 358.

For while its ideological message was widely rejected, the mission enmeshed local peoples in the underlying forms of the European system.<sup>7</sup>

The Comaroffs make an intriguing distinction between ideology, “an articulated system of meanings, values, and beliefs,” and the practical or physical forms that compose hegemony, “that order of signs and practices, relations and distinctions, images and epistemologies...that come to be taken-for-granted as the natural and received shape of the world.”<sup>8</sup>

In this chapter, I examine the character, impetus, and goals—or ideology—of Mengo Hospital’s founders, and how they pursued that ideology through the physical forms of clinical record keeping and the hospital’s buildings. Albert Cook and Katharine Timpson Cook built Mengo Hospital, and their lifelong devotion to “saving” the Baganda, both body and soul, guided its development. The records and forms for medical practice and the physical space of buildings were informed by, and sought to promote, their ideology as medical missionaries. Therefore, when Baganda patients passed through Mengo Hospital, they physically experienced and, in the words of the Comaroffs, became “enmeshed” in the Cooks’ evangelical missionary idea of colonial medical social arrangements. How patients and their kin made meaning of that experience and whether that meaning accorded with the missionary narrative, encompassing ideology and hegemony, is then the focus of my essay.

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<sup>7</sup> Jean and John L. Comaroff, “The colonization of consciousness in South Africa,” *Economy and Society* 18, no. 3 (August, 1989): 267.

<sup>8</sup> Jean and John L. Comaroff, *Of Revelation and Revolution, Volume 1: Christianity, Colonialism, and Consciousness in South Africa*, (Chicago: University of Chicago Press, 1991), 1:23-4.



Image 3: Two “Native” assistants carrying Katharine Cook <sup>9</sup>

### **Doctor and Nurse, Husband and Wife**

As medical missionary pioneers, Albert and Katharine Cook, who married in 1900, three years after arriving together in Uganda, built and designed Mengo Hospital to effectuate the hegemony of the Protestant colonial state. They epitomize the contradictions

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<sup>9</sup> “Mrs. A.R. Cook Crossing A River in Koki,” in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 270.

and paradoxes characteristic of imperial evangelization in a colonial situation. Paternalistic, and fundamentally racist and condescending, they made it their life's work to "save" others for Christ, to rescue them from "heathenism" and to "lift them up" socially. Their particular focus was to "educate natives" in European medicine and mores.

Albert Cook and Katharine Timpson Cook's personalities reflected twin impulses: "to save, but also to control" in the phrase of Ellen Poteet.<sup>10</sup> By and large, Cook had a reputation for generosity of spirit. Roy Billington, Mengo's Superintendent from 1937-1970, remembered that "his kindly ways were well known. 'How is the little mouse today?,' Cook would say gently to the mother of a nervous child, and his ward rounds were punctuated with friendly greetings, jokes, and proverbs."<sup>11</sup> Billington's recollection of Cook's benevolence does not necessarily reflect how the Baganda reacted to Cook, but does confirm that Cook manifested genuine interest in the well-being of his patients. H.C. Trowell, a fellow physician in Uganda, who described Cook as a "big-hearted man," said that Cook's medical and missionary work was "grounded in compassion and born in charity."<sup>12</sup> At the same time, Cook was a disciplinarian and brooked no insubordination. During the Nubian Mutiny in 1897, Cook beat his "native boy" for comparing him to a hyena in having exhumed female Baganda corpses for an investigation of female Baganda pelvis size. Cook then wrote to his colleague, Dr. Mitchell, "[a]s we were under military discipline, [referring to the mutiny] I

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<sup>10</sup> Ellen Poteet, personal discussion, (discussing missionaries, generally).

<sup>11</sup> Ibid. Billington's remembrance of Cook's benevolence does not reflect how the Baganda reacted to Cook, but does illustrate that by European standards of the day, Cook comported himself with genuine interest in the well-being of his patients.

<sup>12</sup> H.C. Trowell "Albert Cook Memorial Lecture, 1956: The medical pioneers and explorers of East Africa" *The East African Journal*, 4, no. 8 (August 3, 1957): 429.

laid him down, and gave him a half a dozen of the best for insubordination.”<sup>13</sup> Nevertheless, Europeans generally remembered him for the softer aspects of his personality.

The same could not be said of Katharine Timpson Cook. Charitable biographers described her as formidable. Trowell recalled that she:

had for many years been a most efficient matron of Mengo Hospital and she tended to show to the full the strains of her office; they [Katharine Cook and her husband] were known as the Red Queen and King, after the characters found in *Alice in Wonderland*. She would go round sentencing people ‘Off with her head’: but the Red King followed behind murmuring ‘Everyone is pardoned.’<sup>14</sup>

Consistent with her controlling character, Katharine Cook, for example, censored the mail of her midwifery students. In a letter to the Headmaster of the CMS Native School, she declared: “Girls who keep up a clandestine correspondence are liable to expulsion.”<sup>15</sup> Like Cook, Katharine Cook took for granted that the moral education of “natives” justified such disciplinary measures. Katharine Cook’s formidable nature also was manifested during the construction of the Lady Coryndon Maternity Training School. The *Sekanyolya*, a newspaper for Baganda youth, wrote: “The wayfarer in these days, should he chance to raise his eyes, is sure to see Mrs. Albert Cook, her clothes soiled by work and with her sun-umbrella, directing the bricklayers and carpenters, and every kind of workmen.”<sup>16</sup> At the opening ceremony for the school, Cook quoted this article and added: “The chief burden of the oversight of the work, the stress and the strain of keeping the workmen up to the mark ... had rested on Mrs. Cook.”<sup>17</sup>

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<sup>13</sup> A.R. Cook “Note on Dr Mitchell’s Paper,” 216 quoted in in Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, NC: Duke University Press, 1999);

<sup>14</sup> H.C. Trowell “Albert Cook Memorial Lecture, 1956: The medical pioneers and explorers of East Africa” *The East African Journal*, 4, no. 8 (August 3, 1957): 429.

<sup>15</sup> K.T. Cook to the Headmaster of CMS Native Schools, December 23, 1929, letter box “A: Copy Letters from A.R. Cook, B: Cook family letters,” ACML.

<sup>16</sup> *Ibid.*

<sup>17</sup> “Opening of the Lady Coryndon Maternity Training School,” *The Uganda Herald*, June 17, 1921.

This odd couple began their journey to Kampala in 1896, when Katharine Cook, then Timpson, was training at Guy's Hospital in London, and Cook was at St. Bartholomew's Hospital, London.<sup>18</sup> Cook, Timpson, and ten other CMS missionaries arrived in Mombasa in September, 1896. At that time there was no road passable by automobile or even bicycle from Mombasa to Kampala, and the British had only just commenced the construction of the Uganda Railroad.<sup>19</sup> To transport their baggage, as well as expensive and heavy medical instruments, the CMS group tried to hire 500 porters. Their promise of 30 rupees per month only convinced 200 porters to make the 850 mile journey across the Taru desert, ford rivers with Europeans on their backs, and brave the potential hostilities of the Masai and the Wakamisia.<sup>20</sup> Malaria, dysentery, and a nutrient-poor diet dogged the porters, but Cook romanticized the safari, writing with nostalgia:

[E]vening meals, sitting around the camp fire, with the firelight thinning on the dark faces, while the hum and stir of the porters from their little huts perched round as they cooked their food, added to the interest of the scene till we sought our tents and one by one the voices died out and solemn African stars shone calmly down on a sleeping camp; unless the grunting growl of a leopard or the distant roar of a lion roused the slumbering Baima (herdmen) to replenish their fire and look to the safety of their cattle.<sup>21</sup>

Cook clearly felt that he had embarked on a daring mission, plunging into the "heart of darkest Africa," where the people were as untamed as the landscape. The group arrived at its destination on February 15, 1897.

What motivated Cook and Timpson to leave the comforts of home and brave the journey to Kampala? Their biographers usually refer to Henry Morgan Stanley's call for medical missionaries. In 1875, Stanley reportedly wrote: "oh, that some practical missionary

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<sup>18</sup> W.R. Billington, "Albert Cook 1870-1951: Uganda Pioneer," *BMJ* 4, no. 5737 (December 19, 1970): 738-40.

<sup>19</sup> Albert Ruskin Cook, *Report to the C.M.S.* Box 2, ACML.

<sup>20</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 21.

<sup>21</sup> Albert Ruskin Cook, *Report to the C.M.S.* Box 2, ACML.



would come here.... It is not a mere preacher that is wanted ... it is the practical Christian tutor, who can teach people how to become Christians, cure their diseases.”<sup>22</sup> In any event, Cook certainly devoted himself to the dual role Stanley encouraged for medical missionaries. He conceived of his work as “being part of the Gospel itself, a demonstration that Christ cared as much for the bodies of men as for their souls, and that His Church should obey His plain command: ‘Preach the Gospel and heal the sick.’”<sup>23</sup> Summing up his medical career in Africa, Cook wrote: “To attempt to heal the suffering body is much/ To carry the water of salvation to thirsty souls is more, but/ To combine the two is the grandest work a man can have.”<sup>24</sup> In his daily routine, Cook mixed moralizing with his medical work. According to Billington:

[H]is Buganda friends today remember that he was never too busy to speak for Christ. In the wards on Sunday he would take the service, wearing his M.D. hood over a surplice, and preach in careful Luganda, quoting the African proverbs of which he was so fond.<sup>25</sup>

The Cooks also employed “native teachers,” men and women responsible for conducting morning Christian services for outpatients, evening services in the gender segregated-wards, and assisting with Sunday services, and also for developing interpersonal relationships with patients as part of the effort “to evangelize the patients.”<sup>26</sup>

Meanwhile, Cook’s enthusiasm for saving African bodies and souls may have influenced his role in popularizing the idea that there was an epidemic of syphilis in Uganda.

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<sup>22</sup> H.M. Stanely quoted in R.T.S. Goodchild, “A Medical Jubilee in Central Africa,” *BMJ* 2, no. 4521 (August 30, 1947): 342.

<sup>23</sup> A.R. Cook *The Mengo Hospital 1897-1937*, 5.

<sup>24</sup> A.R. Cook quoted in W.R. Billington, “Albert Cook 1870-1951: Uganda Pioneer,” *BMJ* 4, no. 5737 (December 19, 1970): 740.

<sup>25</sup> W.R. Billington, “Albert Cook 1870-1951: Uganda Pioneer,” *BMJ* 4, no. 5737 (December 19, 1970): 739; Tuck claims that patients were expected to confess their sins, but upon checking Tuck’s sources for this claim I found that one of the case notes Tuck referenced had been removed and that Tuck misquoted the other.

<sup>26</sup> J. H. Cook to CMS, November 30, 1909, Reel 439 Original Papers 1910, Section IV, Part 20, Church Missionary Society Archive.

Davies wrote: “there was no real epidemic of syphilis, and so far as there was an ‘epidemic’ he [Cook] himself was the origin in that he created... and by his energy and enthusiasm convinced others that it was an ‘epidemic spread’ in an ‘explosive outbreak.’”<sup>27</sup> A syphilis outbreak provided Cook with what he perceived as a happy opportunity to provide care both for patients’ bodies and their souls.

As part of their evangelical, medical, and civilizing mission, the Cooks were also called to educate natives in medical practices. When he arrived in Uganda, Cook quickly learned Luganda, and published an English-Luganda Medical phrasebook intended not just for British medical practitioners, but also for “our own native assistants at Mengo Hospital, who are learning English the more thoroughly to equip them for systematic instruction in the medical sciences.”<sup>28</sup> In 1917, Cook founded Uganda’s first medical school. Two years later, Katharine Cook opened and became the first matron of the Lady Coryndon Maternity Training School. Finally, Katharine Cook also opened a nursing school in 1928.<sup>29</sup> These programs to educate “natives” combined strains of humanitarianism—an impulse to rescue—and colonial paternalism—an urge to infantilize and control.

Albert and Katharine Cook, paternalistic, determined to impose their moral values on the Baganda, but also genuine humanitarians, approached medical care with a determination to cure bodies, save souls, and “better,” the “natives” and even incorporate them into the pursuit of their missionary medical objectives through education.

## **Intake**

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<sup>27</sup> J.N.P. Davies, “The History of Syphilis in Uganda,” *Bulletin of the World Health Organization* 15 (1956): 1050.

<sup>28</sup> A.R. Cook, *A medical vocabulary and phrase book in Luganda* (Kampala, Uganda & London: Uganda Book Shop & Society for Promoting Christian Values, 1921) 7.

<sup>29</sup> W.R. Billington, “Albert Cook 1870-1951: Uganda Pioneer,” *BMJ* 4, no. 5737 (December 19, 1970): 739. Because the focus of my analysis is the 1910s and 1920s, I have not examined the history and impact of the nursing school.

Thus these two pioneers, Albert Cook and Katharine Timpson Cook, brought to bear their vision of the practice of medicine as a colonial evangelical endeavor, to cure physically and morally, into the everyday functions of the Hospital. The printed case sheets prepared for each patient reflected this dual mission that joined moral uplift with medical care. Moreover, the case sheets took on a life of their own; they were the invariant side of a structured conversation. They created a rubric for information collection that the Mengo Hospital physicians found relevant to their work: though silent, they dictated what would be written down, recorded, and archived, as well as what would be ignored. It is true that the CMS doctors could elect not to adhere strictly to the form and answer all the case note questions, and did occasionally add additional information in the margins of the case notes. By and large, however, the printed form seems to have guided a doctor-patient interaction, in which, in addition to physical information, a patient's religion featured as a category of knowledge relevant to the provision of care at Mengo.

The majority of questions on the pre-printed sheets are directed towards either locating the patient: ward, bed, patient number, name, date of admission, date of discharge, or making a medical diagnosis and effecting a medical "cure:" disease, history of present illness, previous illnesses, present condition. Beyond that, as noted above, the forms also recorded patient religion. Soliciting and relaying such information to CMS and to potential donors was important for the mission's fund-raising. At the same time, it seems possible that a patient's religious affiliation could also influence care-givers' attitudes toward patients, and affect such matters as a patient's bed location, or daily hospital activities, and even overall quality of care.

Cook’s recorded statistics on patient religion give a literal answer to how patients reacted to being asked for their religion.

Table 2: Religious Affiliations of Mengo Hospital In-patients, 1908<sup>30</sup>

Baptized Protestants	661
Gospel readers	44
Infants	202
Roman Catholics	203
Mohammedans	77
Heathens	198
Brahmins	6
Hindus	7
Jews	1
Unascertained	6

Table 3: Religious Affiliations of Mengo Hospital In-patients, 1913<sup>31</sup>

Baptized Protestants	812
Gospel Readers	40
Infants	260
Roman Catholics	230
Mohammedans	137
Heathen	278
Hindus	86
Sikhs	2
Various	5

This data makes clear that non-Protestants sought care, and stated their religion, at Mengo, and that the proportions of Baptized Protestants and “heathen” patients among the total remained relatively constant between 1908 and 1913. The greatest percentage increase in patient religious affiliation in those years was in Hindus with over a 12-fold increase, likely a reflection in the rise of Kampala’s South Asian population during this period. The number of “Mohammedans” provided care almost doubled, while “Roman Catholics,” and “Infants,” a group that seems to have been of particular interest for evangelical missionaries, both increased modestly. In both 1908 and 1913, Baptized Protestants comprised the vast majority of patients at Mengo, indicating that it was clearly accepted as a mission church

<sup>30</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 273.

<sup>31</sup> “C.M.S. Medical Hospital” *Uganda Herald*, December 19, 1913.

hospital for converts. Meanwhile, data in church registers makes it unlikely that patients might have perceived an advantage in pretending to be Baptized Protestants at Mengo.

Although it is not so immediately obvious, other aspects of the printed case sheets also had evangelical implications. Instead of “Reason for Visit,” the case sheets specifically asked for the patient’s “Disease,” “History of Current Illness,” and “Previous Illnesses.” Thus, Mengo Hospital was focused on biomedical disease, and cure, not prevention. As discussed in later chapters, this type of curative care at Mengo did not always address Africans’ ailments as they understood them, and therefore did not provide the kind of treatment they sought. At the same time, this brand of care also aimed to attract a particular patient population – one that the missionaries judged would be predisposed to evangelization because of their illness.

The information not printed in the case sheets also reflects how missionary staff approached patients. Thus the forms do not record the patient’s age, height, weight, or gender. This intimates that these forms were not used for purposes of medical review, and instead functioned as a form of record-keeping for the hospitals’ missionary functions: holding sermons and morality classes, and arranging patients in ways to promote conversion.

### **Buildings**

Much like the printed case sheets, Mengo Hospital’s buildings were physical manifestations of Albert and Katharine Cook’s desire to cure and “save,” but also to incorporate “native” patients into an evangelized colonial system and to remake the Baganda in their own image. The buildings of Mengo Hospital therefore aimed to showcase the material advances of Western technology, enforce British racial theories, and impose and propagate Protestant mores. While the continuous nature of historical processes often defies

attempts to determine ruptures, I divide Mengo Hospital's construction into phases corresponding to the three ways that Cook and his wife Katharine Cook, consciously changed the spatial configuration over time. The first phase extends from 1897 to 1904, during which time Mengo Hospital was under continual construction and revision, increasing the hospital's capacity both to cure, and to impress with Western technology.

The second phase began in 1904 and reached its height in 1913, with the construction of separate Indian and European wards. Racial divisions always existed at Mengo Hospital, where white doctors and nurses always occupied dominant positions over African medical assistants and patients; and another category—South Asian patients—neither white nor black—received its own space. The construction of racially segregated wards emphasized and enforced colonial racial divisions and held implications for quality of medical care.

During a third phase of “native” education from 1917 to 1939, the Cooks designed spaces to promote moral conversion, particularly the indoctrination of Protestant views on respectability and sin. Though this process began with the founding of Mengo Hospital, the construction of separate wards for Africans and Europeans, and the development of the midwife training program significantly extended the potential capacity to deliver moral and religious messages to “natives.”

Between 1897 and 1904, the CMS built three iterations of Mengo Hospital, each showcasing more of the supposed benefits and advances of Western technology. The first incarnation opened on May 14, 1897, three months after Cook arrived in Uganda. In his memoir, Cook wrote that the first hospital “consisted of two huts with reed walls, thatched roofs, and mud floors.”<sup>32</sup> The houses, one for patients of each gender, were centered around a large fire pit. Each house contained six hand-made beds, with dried banana leaves (*byai*)

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<sup>32</sup> A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 47.

for mattresses, and barkcloth curtains.<sup>33</sup> These conditions—Cook called them “primitive”—provided few opportunities to display the technological power of Western medicine. Cook wrote that: “Our first operation was carried out on a camp bedstead for operating table, the instruments being sterilized in a saucepan and laid in vegetable dishes or plates filled with antiseptics, in lieu of surgical instrument trays.”<sup>34</sup> While at the time the Cooks had to improvise with materials at hand, their growing popularity and increasing revenue from patient fees allowed them to purchase more sophisticated medical equipment over time.



Image 4: The First Mengo Hospital<sup>35</sup>

During the next three years, the attendance of in-patients grew rapidly, and the original hospital, even with additional expansions, could no longer meet the demand for treatment.<sup>36</sup> On May 31, 1900, Sir Harry Johnston, a famous missionary, opened a new

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<sup>33</sup> Ibid., 47-8.

<sup>34</sup> Ibid., 47.

<sup>35</sup> “Mengo Hospital, 1897: Operating Theatre on Left” in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 46.

<sup>36</sup> Ibid., 115.

building, constructed in the shape of a cross.<sup>37</sup> The new hospital was drastically larger, with room for twenty-five beds for men and twenty-five beds for women and children in separate wards, but still built from “primitive” materials: a thatch and reed roof, mud and wattle walls, and banana leaf (*byai*) mattresses. Nonetheless, Cook wrote that the building was “the finest (at that time) in the Protectorate.”<sup>38</sup> In 1902, the second Mengo Hospital caught fire during a thunderstorm and burned to the ground.<sup>39</sup> During the panic the fire produced, over zealous Baganda destroyed some of the expensive equipment Cook had acquired, most notably glass-fronted instrument cabinets, that were thrown out a window.<sup>40</sup> With the fire, Cook’s design to display Christian Europe’s technological superiority suffered a temporary setback, but the third iteration of Mengo Hospital would become the preeminent display of biomedical technology in Uganda and possibly in all of East Africa.



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<sup>37</sup> Ibid., 134-5.

<sup>38</sup> Ibid., 135.

<sup>39</sup> R.T.S. Goodchild, “A Medical Jubilee In Central Africa,” *The British Medical Journal* 2, no 4521 (August 30, 1947): 342.

<sup>40</sup> Ibid., 342.



### Image 5: The Second Mengo Hospital<sup>41</sup>

In response to the destruction of the second Mengo Hospital,<sup>42</sup> Sir Apolo Kagwa, the *katikiro* or Prime Minister of the Kingdom of Buganda, announced: “If God has allowed our hospital to perish, it is to show us that we must build a bigger and better one.”<sup>43</sup> Cook took Kagwa’s words to heart, constructing the new Mengo Hospital out of Western building materials, and parading cutting-edge biomedical technology in it. This final version of Mengo Hospital, still standing today, opened two years to the day from when the second Hospital caught fire, on November 28, 1904.<sup>44</sup> This hospital was made of sundried brick, with a burnt brick foundation, corrugated iron roofing, and cement floors.<sup>45</sup> It was laid out in what Cook described as “a double Maltese Cross, with an annexe [sic] at each end.”<sup>46</sup> All rooms had spacious, fourteen-foot ceilings. The hospital’s central block contained a dark room for optometry, an anesthetic room, an operating room, and a sterilizing chamber. Cook imported the operating table from England, and both operating room and sterilizing chamber were “painted with petrifying fluid, a highly glossy white enamel.”<sup>47</sup> Finally, a staircase led up to a pathology tower on the second floor. Thus, with this last Mengo Hospital, the Cooks constructed a sort of shrine to modern biomedical ideals, with sterile white enamel and the

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<sup>41</sup> “The Second Mengo Hospital, 1900: Destroyed by Lightning, 1902,” in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 134.

<sup>42</sup> After the fire, Col. Sadler, the Commissioner of Uganda, had four hundred “native laborers” “volunteer” for one month to construct a temporary hospital.

<sup>43</sup> W.D. Foster, “Dr Albert Cook and the C.M.S. Medical Mission to Uganda,” *Med. Hist* 12, no. 4 (October, 1968): 336.

<sup>44</sup> *Ibid.*, 336-7.

<sup>45</sup> A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 203.

<sup>46</sup> *Ibid.*, 203.

<sup>47</sup> *Ibid.*, 203.

resources to sustain more rigorous, sterile scientific research focused on identifying a disease's microscopic etiology.<sup>48</sup>

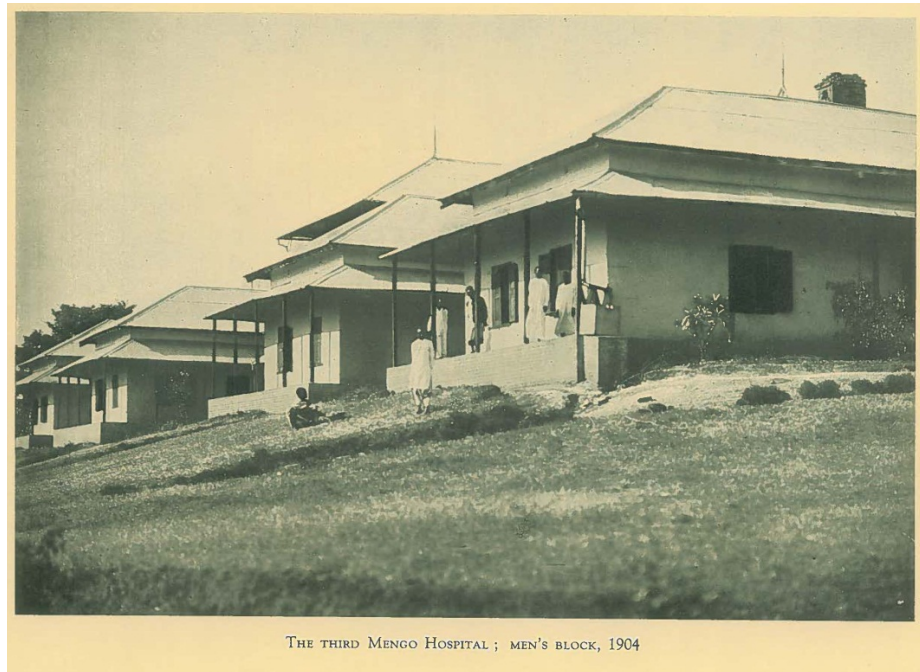


Image 6: The Third Mengo Hospital<sup>49</sup>

Although Mengo Hospital's building projects after 1904 focused less on showing off Western medical and technological advances, the hospital continued to incorporate the most sophisticated technology possible. By 1910, for example, Mengo had electricity, and Cook introduced the first x-ray machine to Uganda.<sup>50</sup> As Luise White illustrates, however, "native" interpretations of these technologies varied wildly from Cook's expectations, as some Baganda saw medical technology for its capacity to harm, even torture, rather than its capacity to save and cure.<sup>51</sup>

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<sup>48</sup> The facilities attracted the likes of Robert Koch, one of the founders of the germ theory, who visited the hospital in 1907. W.R. Billington, "Albert Cook 1870-1951: Uganda Pioneer," *BMJ* 4, no. 5737 (December 19, 1970): 739.

<sup>49</sup> "The Third Mengo Hospital; Men's Block, 1904," in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 202.

<sup>50</sup> R.T.S. Goodchild, "A Medical Jubilee in Central Africa," *BMJ* 2, no. 4521 (August 30, 1947): 343.

<sup>51</sup> Luise White, "'They Could Make Their Victims Dull': Genders Genres, Fantasies and Cures in Colonial Southern Uganda," *The American Historical Review* 100, no. 5 (December 1995): 1379-1402.

Suggesting how Mengo Hospital might shape space in the future, the third Mengo Hospital also contained private wards for chiefs and for their wives.<sup>52</sup> While Mengo continued to exhibit the wonders of the Western world, construction of Mengo after 1904 began to refine the architectural articulation of colonial hierarchies. With the provision of separate rooms for chiefs and their wives, Mengo started applying the social hierarchies that supported indirect rule. To that end, the dispensary, the space through which all patients passed and from which patients were admitted to the hospital proper, became a gateway to processing the mass of patients into separate social classes. A month before completing the third hospital, in 1904, Cook persuaded Sir Henry Wellcome, the wealthy pharmaceutical entrepreneur and philanthropist, to fund a new dispensary. A separate building from the hospital, the Wellcome Dispensary opened in October 1905. Like the third hospital, it incorporated modern Western building materials: cement floor and corrugated iron roofing. The dispensary funneled patients from consultation and diagnosis to prescription pick-up. Patients first waited to see the doctor on a roofed porch, where they were separated by gender and triaged according to severity of illness. When called, patients entered one of two consulting rooms, where a doctor examined them. The CMS furnished each consulting room with a couch, screen, washstand, and table.<sup>53</sup> After diagnosis, patients either waited in a large interior hall for their prescriptions, or, if admitted for treatment, were escorted to the main hospital. Benches reserved for African chiefs and Indians lined the walls of the hall.<sup>54</sup> In passing through the consultation room, then, people, who before diagnosis had been simply male or female “patients,” became categorized as chiefs, Indians, or “natives.” Thus,

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<sup>52</sup> A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 203.

<sup>53</sup> W.D. Foster, “Dr Albert Cook and the C.M.S. Medical Mission to Uganda,” *Med. Hist* 12, no. 4 (October, 1968): 337.

<sup>54</sup> *Ibid.*, 338.

Cook and Henry Wellcome, the British pharmaceutical entrepreneur and philanthropist, designed the dispensary to provide efficient medical service, but also to distinguish “natives” from chiefs and South Asians.

“Natives,” however, even if treated as such, did not compose a homogenous group. The historical record shows that there were religious, linguistic, and ethnic divisions within this group.<sup>55</sup> Goodchild, writing in 1947, described the cacophony of languages in a ward with “a Munyarwande here lying beside a Muganda, with a Mutoro opposite, and a Teso or Lango nearby and occasionally a member of some tribe from Kenya or the distant Belgian Congo.”<sup>56</sup> Infrastructure development in Uganda no doubt contributed to the diversity Goodchild recalled, but Cook described similar diversity in his case notes and statistics.<sup>57</sup> Mengo Hospital’s jumble of ethnicities mirrored colonial polities that simultaneously emphasized and even constructed “tribal” ethnicities, but still united them under a single administrative system.

While Mengo Hospital took no account of distinctions among African ethnicities, it accentuated the divide between Africans, chiefs, Indians, and especially, Europeans. “African diseases” and their human vectors terrified Europeans, who surely expected segregated medical care. For example, shortly after the 1908 report by Lambkin “confirmed” the syphilis epidemic, stories circulated of African nurses infecting European children.<sup>58</sup> In December of the same year, the CMS Medical Subconference decided: “No natives [are] to be allowed the use of any European’s house, owing to the danger of introducing ticks, or any

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<sup>55</sup> I suspect that the commoners were further divided along economic, educational, and political axes.

<sup>56</sup> R.T.S. Goodchild, “The Jubilee of Mengo Hospital” 1947, ACML.

<sup>57</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ARCLM, 1923. Ludiya Osuka admitted November 7, 1921; Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ARCLM, 2187. Eisa Musajugyaguada admitted November 24, 1921.

<sup>58</sup> “The Irony of the Comparison.” *The East African Standard* February 22, 1908.

other noxious insects.”<sup>59</sup> Anxious about Africans spreading disease, and heeding the public demand for a private European ward, Cook started planning a European Block in July, 1909, and on March 9, 1912, opened the Annie Walker Memorial Hospital (AWMH), for Europeans only.<sup>60</sup>

Though Cook intended to isolate Europeans from “African diseases” inside the AWMH, the Western patients brought “African” diseases with them. J.S.M. Byass, for example, presented a dizzying array of symptoms: vomiting, insomnia, and headache—and was diagnosed with syphilis in 1915. In his case note, Cook wrote:

Exposed to syphilitic [sic] infection between 6 or 8 weeks ago. Intense irritation inside and outside the foreskin for some weeks. He has not been able to draw back the foreskin for some weeks. 3 weeks ago he noticed a small pimple or sore on the foreskin. Has been irrigating the glans and there has been some haemorrhaging [sic] from inside the foreskin.<sup>61</sup>

Byass evidently suffered from phimosis as a consequence of syphilis, for Cook circumcised him the day after his admission.<sup>62</sup> Byass’s case is remarkable not simply because it makes clear that Europeans contracted the disease, but also because, in contrast to many Baganda patients, Byass obviously attached a stigma to the disease, as underlined by his efforts to cure himself before seeking treatment at Mengo. Byass was not alone among Europeans. In 1921, Christopher J. Graham, 38, was treated for syphilis at the AWMH. Ernest Cook, Albert Cook’s nephew, took Graham’s history:

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<sup>59</sup> Minutes, December 9, 1908, “Medical Subconference Meeting Minutes,” 1908-1925 (A.R. Cook Secretary), ACML. The Medical subconference was comprised of Rev. J Roscoe, and doctors Albert Cook, Jack Cook, and Bond.

<sup>60</sup> W.D. Foster, “Dr Albert Cook and the C.M.S. Medical Mission to Uganda,” *Med. Hist* 12, no. 4 (October, 1968): 339; Theodore Walker of Leicester funded the construction of the European only ward and named it after his wife who died at sea *en route* to Uganda. The incumbent Governor, Fredrick Jackson, opened the new ward. Some 100 Europeans, quite a large gathering for the time, attended the inaugural ceremony. A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 291.

<sup>61</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 948. J.S.M. Byass admitted May 11, 1915.

<sup>62</sup> For more information on phimosis see patient section in Chapter Two.

Had syphilis in 1918 when he had 2 injections of Hg [mercury] intravenous. Then Hg by mouth for one year but quite irregularly. In S. Africa 1920, he had 9 injections of 606 and 6 of mercury. [...] Had old gonorrhoea [sic] also. At present he sleeps badly at night but has been taking a certain amount of alcohol.<sup>63</sup>

It appears that Cook was very discreet in his approach to Europeans with venereal disease: he treated them in a separate wing, and did not publicize their ailments. Such cases led Nakanyike Musisi, a Uganda historian, to assert: “Cook’s suppression of this knowledge [incidence of European venereal cases] created an overall racialized perception that immorality was a “native” problem.”<sup>64</sup> Verifying Musisi’s charge of intentional suppression would require a more thorough analysis of the European cases at Mengo Hospital, but at the least, there does not appear to have been a shortage of European cases of venereal disease. Accordingly, while the AWMH was purportedly built to protect Europeans from “African disease,” it also fostered the fallacious narrative that syphilis was an “African disease” reflecting moral failings of Africans that were not shared by Europeans.

In other ways too, the AWMH made the purported racial superiority of Europeans a physical reality. The contrast between the care delivered at AWMH and at the “native” portions of Mengo Hospital thus furthered colonial racism. For the time, the AWMH was luxurious. A newspaper article in *The Uganda Herald* recounted that: “the furniture has been selected with the greatest care; beautiful pictures adorn the walls. [T]he aim of making it as much like home as possible has been admirably achieved.”<sup>65</sup> Cook described how his European patients could be “wheeled out on to the veranda [to] feast their eyes on the

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<sup>63</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, 32. Christopher J. Graham admitted March 7, 1921.

<sup>64</sup> Nakanyike Musisi, “The Politics of Perception of Perception as Politics? Colonial and Missionary Representations of Baganda Women, 1900-1945,” in *Women in African colonial histories*, ed. Jean Allman, Susan Geiger, and Nakanyike Musisi (Bloomington, IN: Indiana University Press, 2002), 107.

<sup>65</sup> “C.M.S. Medical Hospital” *Uganda Herald*, December 19, 1913.

magnificent view” of an emerald green lawn and garden “sloping away from the building ... with an arbor for afternoon tea.”<sup>66</sup> Additionally, the case notes demonstrate that the physicians devoted more attention to European patients than to Africans. While African patients’ histories often occupy only a single line in the notes, those of European patients are lengthy paragraphs.<sup>67</sup> Mengo Hospital, therefore, directed significant resources and attention towards its relatively small group of European patients and maintained colonial racial hierarchies in the process.

As the allocation of resources at Mengo seems directed, whether consciously or not, towards bolstering colonial prejudices and hierarchies, so also it appears that the treatment setting and protocols were fitted to instill the missionaries’ medical and moral hegemony. On December 21, 1909, during a hunting trip to Africa, Theodore Roosevelt, the former President of the United States, opened a newly constructed portion of the Hospital.<sup>68</sup> Cook described the Roosevelt Block, an isolation ward, as the “Native Hospital for venereal and contagious diseases.”<sup>69</sup> The building, 130 feet long, was made of brick and corrugated iron roofing. The windows were covered with mosquito-proof wire gauze. The walls were painted white above chrome green. The building comprised two large wards, three smaller wards, a room for the native nurses, a central hall, and an operating room.<sup>70</sup> Within the

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<sup>66</sup> A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 292.

<sup>67</sup> Because Cook was fluent in Luganda, the “language barrier” seems a weak excuse for the enormous discrepancy between the level of detail for European and African case notes.

<sup>68</sup> A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 275.

<sup>69</sup> “C.M.S. Medical Hospital” *Uganda Herald*, December 19, 1913. After the fire in 1902 destroyed the second Mengo Hospital, infectious cases were seen for seen years in the temporary hospital Col. Sadler’s “volunteers” had hastily constructed. The new isolation wards were according to Cook, “everything the old wards should have been, and were not.” A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 273-4.

<sup>70</sup> A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 274.

wards, CMS staff enforced gender segregation, an eight o'clock curfew, and possibly other limitations on patient mobility and social life.<sup>71</sup>

These two isolation wards enabled the medical missionaries to undertake their missionary efforts, that is, to influence patients to accept not only Western medicine, but Protestant Christianity, and British middle class morals, at a time when patients were likely to be most “impressionable”—sick, in unfamiliar surroundings, and isolated. Cook declared that “[n]o part of the hospital work is more important from a medical, evangelistic, or moral point of view” than the isolation wards for venereal disease patients.<sup>72</sup> Thus Cook thought that these patients were particularly susceptible, and targeted them. He characterized them as “[t]hose whom even their not-over-scrupulous heathen friends refuse to receive into their huts, and turn from with loathing.”<sup>73</sup> Cook claimed that these patients had been abandoned by their kinship groups, and so forced to seek refuge and compassion at Mengo Hospital. Cook boasted of how effective his mixture of medical and moral treatment could be in these cases, stating that “in nine cases out of ten, [the isolation patients were] sent out, often after months of treatment, well in body and improved in mind.”<sup>74</sup> Yet it is uncertain how successful CMS medical missionaries really were at propagating their evangelical and sexual mores in these patients.

In 1917, Katharine Cook proposed pursuing another potentially receptive (read, vulnerable) group outside the boundaries of Mengo Hospital: pregnant mothers with venereal disease. Although midwifery education began in Mengo Hospital as early as 1891, it was not until 1921 that the CMS opened a separate building, the Lady Coryndon Maternity Training

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<sup>71</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 880. Mohomat Rahan admitted April 30, 1915.

<sup>72</sup> A.R. Cook, *Uganda Memories, 1897-1940* (The Uganda Society, Kampala 1945), 274.

<sup>73</sup> *Ibid.*, 274.

<sup>74</sup> *Ibid.*, 274.



School (LCMTS) for this purpose.<sup>75</sup> The building comprised three stories, built of brick with a carved black oak staircase, and a separate entrance for European women. As with all of Mengo Hospital's buildings, the LCMTS provided religious as well as medical education. At the school's opening, Cook referred to an engraving inside the building's entrance, of the Good Shepherd seeking the lost lamb.<sup>76</sup> In reaction to this gesture, a local news reporter stated: "It was surely no fancy to imagine the innocent childhood of Uganda beset by the wolves of ignorance, cruel native customs, and venereal disease."<sup>77</sup> Indeed, the Cooks viewed the LCMTS as a "remedy" to the spread of venereal disease and the diminishing Baganda population.

Husband and wife intended these midwives to "save" the Baganda, not simply through their medical skill, but by inculcating Protestant Christian sexual mores. Accordingly, they selected candidates for the LCMTS for their moral character as much as their intelligence. Cook wrote: "The best scholars did not always possess the most stable moral characters. Many of them came from homes of doubtful virtue. The anxious question was not so much: 'Would some fall?' as 'Would any stand?'"<sup>78</sup> Husband and wife continued to infantilize the midwives, assessing their moral character even after the midwives were graduated from the school. For example, the CMS suspended Luzi Byoleka for "having a man in her bed with her," noting that the man "entered by the window and not by the door."<sup>79</sup>

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<sup>75</sup> "A few facts about history and work of Mengo Hospital" ACML pg 1. The opening was the subject of considerable fan-fare. A host of dignitaries, including the Governor, the Chief Secretary, the District Commissioner, the Provincial Commissioner, the King of the Baganda, (*Kabaka*) Daudi Chwa, and the Baganda Prime Minister (*katikiro*) Sir Apolo Kagwa. "Opening of the Lady Coryndon Maternity Training School." *The Uganda Herald* Kampala June 17, 1921.

<sup>76</sup> "Opening of the Lady Coryndon Maternity Training School." *The Uganda Herald* Kampala June 17, 1921.

<sup>77</sup> Ibid.

<sup>78</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 331.

<sup>79</sup> R.T.B. Leakey to A.R. Cook, August 25, 1933, Incoming General Correspondence 1932-1934. ACML.

Such lapses in moral behavior were not tolerated, since the Cooks wanted these midwives to inspire fellow Baganda to accept the CMS's moral teachings.<sup>80</sup>

Ironically, while devoting such care to fostering the midwives' moral capability, the CMS discovered that ethnic tensions inhibited the midwives' effectiveness. In a private letter, Keane complained to Cook: "Outlying districts will not have Baganda staff and if we force them, they are merely persecuted and the Baganda themselves do not like service in the outlying districts."<sup>81</sup> This ethnic backlash against Baganda midwives suggests that Protestant ethics and sexual mores did not "read" in rural Uganda, so that the midwives were unlikely to be successful in attaining the missionaries' goal.

## **Conclusion**

Mengo Hospital's founding physician and nurse arrived in Uganda with a clear evangelical purpose to provide biomedical curative care that might influence grateful patients to accept their "moral" cure as well. To that end, the CMS attempted to use all the "tools" at hand, infusing the forms of treatment, and even the Mengo buildings, with social and moral significance. Mengo Hospital sought to display the wonders that would unfold if Uganda developed along a course that British missionaries would guide. It also maintained social distances to protect racial fallacies and perpetuate social hierarchies. While we know little of how additional "categories" of patients that were established—chiefs and South Asians—fared, it is clear that the care at Mengo Hospital was highly racialized: while "natives" received care in isolation wards, Europeans did not. This racialization of care through

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<sup>80</sup> As Megan Vaughan points out "there are severe limitations to the applicability of the theory of hegemony," namely that Gramsci was describing a strategy for taking over the state, but in a colonial context the state was already "taken." Megan Vaughan, "Health and hegemony: representation of disease and the creation of the colonial subject in Nyasaland," in *Contesting Colonial Hegemony: State and Society in Africa and India* eds. Dagmar Engels and Shula Marks (London: British Academic Press, 1994), 201.

<sup>81</sup> G.J. Keane to A.R. Cook, April 13, 1932, Incoming General Correspondence 1932-1934. ACML.

isolation wards allowed for privileged moral access to native “souls.” As examined in the next chapter, however, Baganda patients entering Mengo Hospital brought with them their own conceptions of illness, their own therapeutic support networks, and their own ideas about missionary and biomedical interventions in Uganda.

## CHAPTER TWO: PATIENTS, KIN, AND SOCIETY

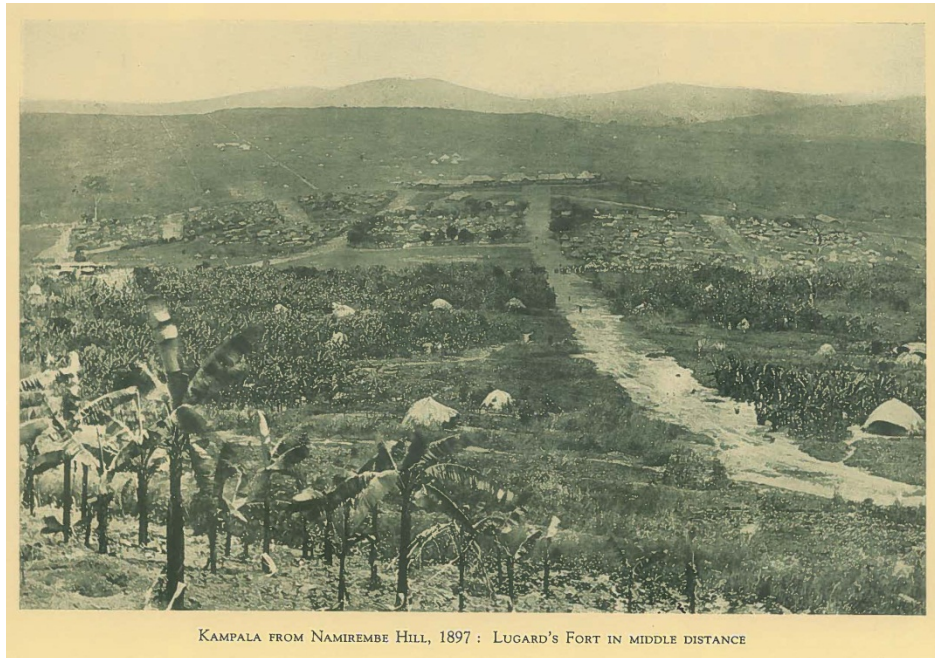


Image 7: View of Kampala from Namirembe Hill, 1897<sup>1</sup>

The sores on Lulyatumanyi’s vulva still had not disappeared in three weeks. The sores were quite shallow, but her labia minora had swollen in response to the infection. Also a rash of solid, dark, scaly bumps covered her entire body. If that were not enough, Lulyatumanyi was five months pregnant with her second child.<sup>2</sup>

Lulyatumanyi’s Mengo Hospital case notes from 1921 do not directly reveal how Lulyatumanyi’s extended family, or kin, reacted to her illness and the threat it posed to her unborn child. The historical and anthropological record, however, demonstrates that the Baganda have long placed enormous importance on a woman’s fecundity and ability to

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<sup>1</sup> “Kampala from Namirembe Hill, 1897: Lugard’s Fort in Middle Distance,” in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 64.

<sup>2</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, Albert Cook Library, Mulago Medical School, Makerere University, Uganda (hereafter referred to as ACML), 2194. Zulula Lulyatumanyi admitted December 26, 1921.

reproduce and expand lineages.<sup>3</sup> It strains credulity to believe that her kin did not react with deep concern, and Lulyatumanyi presented herself at Mengo, presumably with the approval, if not the active support, of her family.

Lulyatumanyi's narrative depicted in her case notes allows us to discern how the Baganda made meaning of their experience at Mengo in the context of a broader crisis in Ganda society before and during the interwar period.<sup>4</sup>

With the exception of the case note buried in Albert Cook's archive, Lulyatumanyi has no other place in the historical record, to the best of my knowledge. Instead, the conventional narrative of the 1897 syphilis epidemic reflects British imperial sensibilities: it is even named for the year Albert Cook, who continues to be portrayed as the predominant actor, arrived in Uganda.<sup>5</sup> In this essay, I seek conversely to understand Baganda patients' experience of illness and treatment and tease out how that experience, as mediated through kinship and general public discourse, reflected and shaped Ganda meanings that differ from the missionary medical narrative. How did they understand their symptoms and illness?

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<sup>3</sup>Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 57-61; 76-87. Nancy Rose Hunt, "'Era of Force' 2: Concept Work, More Examples of Violence, Refusal & Public Healing, University of Michigan, Ann Arbor, February 2, 2012; Although sexual values have undoubtedly evolved over time, during my stay in Uganda, many Muganda women told me that producing large families was one of their most cherished aspirations.

<sup>4</sup>Mikael Karlström, "Modernity and Its Aspirants: Moral Community and Developmental Eutopianism in Buganda," *Current Anthropology* (December, 2004), 601-2; Michael William Tuck, "Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda" (PhD diss., Northwestern University, 1997), 117-125; Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 57-61; 76-87.

<sup>5</sup>J.N.P. Davies, "The History of Syphilis in Uganda," *Bulletin of the World Health Organization* 15 (1956): 1041-55; Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," *Signs* 16, no. 4 (Summer, 1991), 787-807; Marynez Lyons, "Sexually transmitted diseases in the history of Uganda," *Genitourin Med* 70, (1994): 138-145; Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford University Press, 1991), 129-52; Megan Vaughan, "Syphilis in East and Central Africa," in *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* eds. Terence Ranger and Paul Slack (Cambridge University Press, 1992), 269-302; Megan Vaughan, "Health and hegemony: representation of disease and the creation of the colonial subject in Nyasaland," in *Contesting Colonial Hegemony: State and Society in Africa and India* eds. Dagmar Engels and Shula Marks (London: British Academic Press, 1994) 172-201.

What was the role of kin in mediating the experience of illness and treatment? Finally, what was the Baganda discourse on syphilis and society?

To that end, starting with primary sources available at the Albert Cook Library and secondary scholarship on Cook, I have sought, like others, such as Orley and Tuck, to recover African voices and to fill in what might be called the “empty spaces” in the case notes: the Ganda stories and interpretations that can be drawn out of what the Mengo missionaries recorded.<sup>6</sup> This chapter considers how Baganda experienced and “made meaning” of venereal disease on personal, kin, and societal levels. My analysis reveals that at the level of the individual, kinship group, and society, Baganda regarded missionary and biomedical conceptions of syphilis and missionary care with ambivalence, and therefore selectively appropriated biomedical technologies.

I begin by relating the clinical presentations of what was diagnosed as syphilis at Mengo Hospital but could sometimes have been yaws. I contrast these Western medical conditions with Ganda conceptions of sickness and health in relationship to *kabotongo*, the Ganda name for a condition that imprecisely correlates with syphilis or yaws. In this section I relate patient symptoms taken from the case notes to medical text book descriptions of the physical manifestation of venereal disease. For the discussion of *kabotongo*, I rely on ethnographic work in secondary sources and Ganda newspaper articles from the 1910s and 1920s. The analysis demonstrates that Baganda patients had a conception of illness incompatible with Western biomedical theories.

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<sup>6</sup> John Orley, “Concepts of Infectious Disease amongst the rural Ganda- with special reference to yaws and syphilis,” in *Nkanga: Special edition on Medicine and Social Sciences in East and West Africa*, ed. F.J. Bennett (Kampala: Makerere Institute of Social Research, 1973), 60-6; Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 47-54; 82-98; 117-125.

I then turn to a topic that has only been superficially explored in relation to the treatment of syphilis in Uganda: the role of kin. Once again, I draw from the case notes and secondary ethnographic work, as well as Cook's descriptions of kin in his memoir, to try to envision how kinship therapy management groups may have influenced the relationship of Baganda patients to Mengo. The evidence is limited, since medical case notes focus on the individual patient, necessarily separating them from kin. I suggest that while playing a significant role in bringing patients to Mengo for care, and in patient care while under treatment, kin harbored reservations about missionary and colonial care.

The ambivalence and reservations that I believe Baganda kinship groups harbored toward syphilis and Mengo Hospital also found expression in public discourse. In this section, I look at how the alleged syphilis epidemic appeared in public discourse; I rely on legislation from the *lukiiko* (Ganda parliament) and descriptions of the *bamalaki*, an anti-colonial religious and political movement, to discern the disparate attitudes of the Kingdom of Buganda's male, mostly urban, elite and of the *bamalaki*, representing a wider, and more rural, demographic group.<sup>7</sup> These sources together show that Ugandan public opinion about the syphilis epidemic was divided.

Finally, I end this chapter with a brief examination of the experience of Europeans who contracted venereal diseases at Mengo. While syphilis, the epidemic, and Western treatment, were all new to the Baganda, and generated debate and doubt among patients, kinship groups, and Baganda society at large, biomedical care for syphilis was not new to Europeans.

## **Patients**

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<sup>7</sup> Ben Jones, *Beyond the State in Rural Uganda* (Edinburgh: Edinburgh University Press, 2008), 118.

In 1965, William Billington, the Health and Welfare Advisor of the Church of Uganda, delivered the Albert Cook Memorial Lecture, in which he explained Ganda etiology. He described two general causes of sickness: “spirit princes” that sorcerers could harness for nefarious purposes, and breaches in social taboos. To explain spirit princes, Billington referred to “*kawali*,” the spirit that causes smallpox, “*kawumpuli*,” the same for plague, and “*omulangira*,” which literally translates as “the Prince,” and is responsible for measles.<sup>8</sup> This conception of disease, relating an invisible spiritual world to sickness, is common in Sub-Saharan Africa, but largely at odds with a biomedical approach to medicine.<sup>9</sup>

The biomedical disease, syphilis, and the Ganda condition, *kabotongo*, represent distinct conceptions. The etiological agent of syphilis is *Treponema pallidum*, a gram-negative spirochaete bacterium. Syphilis is known as the “Great Imitator” because its symptoms are so diverse. The disease usually progresses through three stages. In primary syphilis, a sore develops at the site of infection. The sore resolves in a matter of weeks. Secondary syphilis is associated with infectious rashes. This stage also resolves without intervention. Only 15% of patients progress to tertiary syphilis, which is manifested years after the initial infection, when *Treponema pallidum* successfully invades the internal organs, including the brain, bones, heart, and nervous system. Tertiary syphilis can be fatal. At all stages, syphilis is also teratogenic—it can cross the placenta and infect a developing fetus, resulting in miscarriage or severe birth defects.<sup>10</sup>

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<sup>8</sup> W.R. Billington, “Interpersonal Relationships in Medicine,” *Albert Cook Memorial Lecture, 1965* (1965), 158. I found this source stored away on a shelf in the ACML.

<sup>9</sup> Pamela Reynolds, *Traditional Healers and Childhood in Zimbabwe* (Athens, OH: Ohio University Press, 1996) 1-40.

<sup>10</sup> Centers for Disease Control and Prevention. “Sexually Transmitted Diseases (STDs): Syphilis – CDC Fact Sheet,” *Centers for Disease Control and Prevention: CDC 24/7 Saving Lives. Protecting People. Saving Money through Prevention*, <http://www.cdc.gov/std/syphilis/stdfact-syphilis.htm> (accessed March 13, 2012).



The causal organism of yaws is *Treponema pertenue*. Morphologically and symptomatically quite similar to syphilis, yaws also progresses through primary, secondary, and tertiary stages. However, unlike syphilis, “[t]he site of entry for yaws treponemes is not usually the genitalia, but often the legs.”<sup>11</sup> Because the primary sores of both yaws and syphilis occur at the site of infection, some of Cook’s syphilis diagnoses may be suspect.<sup>12</sup> Additionally, yaws is associated with tropical climates and poverty: “Yaws is generally considered to be a highly contagious disease in tropical areas of the world, and in populations with limited hygiene.”<sup>13</sup> These distinctions, however, are slight, and syphilis and yaws continue to be confused.<sup>14</sup>

Descriptions of patients suffering all three stages of syphilis (or possibly yaws) can be found in the case notes from Mengo Hospital. Yokana Muwerezza, who was treated in 1915, showed signs of both primary and secondary syphilis. Muwerezza professed himself a “Baptized Protestant.” He first noticed something amiss a month before coming to Mengo Hospital, when a sore appeared on his right foot. On May 4, 1915, Cook recorded that the sore was “on his right foot under the 3<sup>rd</sup> toe.”<sup>15</sup> The fact that the sore was on his toe, instead of his genitals, suggests Muwerezza could have suffered from yaws. Cook’s examination also revealed evidence that Muwerezza had syphilis, perhaps in addition to yaws: another sore, this one on the penis.<sup>16</sup> In the staged development of syphilis, typically a chancre first appears at the site of inoculation, and eventually grows into an ulcer. Although hideous,

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<sup>11</sup> Don R. Brothwell, “VIII.157:Yaws,” in *The Cambridge World History of Human Disease*, vol. 1, ed. Kenneth F. Kiple (Cambridge University Press, 1993), 1097.

<sup>12</sup> Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 232.

<sup>13</sup> Don R. Brothwell, “VIII.157:Yaws,” in *The Cambridge World History of Human Disease*, vol. 1, ed. Kenneth F. Kiple (Cambridge University Press, 1993), 1096.

<sup>14</sup> *Ibid.*, 1098.

<sup>15</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 910. Yokana Muwerezza admitted May 4<sup>th</sup>, 1915.

<sup>16</sup> *Ibid.*

characteristically these ulcers are painless.<sup>17</sup> In addition, Muwereza had a “phimosed prepuce”, a complication of syphilis infection, in which the foreskin tightens around the opening of the penis. Phimosis can prevent urination and may require corrective surgery.<sup>18</sup>

Muwereza also exhibited symptoms typical of secondary syphilis, with “a crescent shaped general eruption with numerous papules [small, solid, rounded, or somewhat pointed swellings] and a very scaly condition of the legs.”<sup>19</sup> These symptoms are characteristic of a papular syphilitic eruption, in which “papules are disseminated all over the body including the face, soles, palms....The early papules are shiny and copper red, but change with the age of the lesion.”<sup>20</sup> These case notes read today as a portrait of suffering: infected foreskin, ulcers, and rashes, with imagery that simultaneously repulses and intrigues, while demanding that one ponder the emotions that must have affected Muwereza.

Case note descriptions make clear that the symptoms of tertiary syphilis were equally, if not more, horrific. Daudi Sempa, a Protestant convert, arrived at Mengo Hospital a day earlier than Muwereza, on May 3, 1915. Cook diagnosed tertiary syphilis, noting that: “Much of the instep of the left foot is eaten away by [a] huge broken down gumma. Another big gumma is over the back of the lower part of the right ulna. A smaller gumma is on the dorsum of the left 4<sup>th</sup> and 5<sup>th</sup> toes.”<sup>21</sup> A gumma is a syphilitic tumor that may be present in all tissues in the body. Gummata appearing on the skin surface degrade gradually, leaving

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<sup>17</sup> Eva Brehmer-Andersson, “Syphilis,” in *Dermatopathology* (Verlag: Springerlink, 2006), 114; *Encyclopædia Britannica Online*, s. v. “chancere,” accessed February 26, 2012, <http://www.britannica.com/EBchecked/topic/105360/chancere>.

<sup>18</sup> T.B. McGregor, J.G. Pike, M.P. Leonard, “Pathologic and physiologic phimosis: approach to the phimotic foreskin,” *Can Fam Physician* 53, no. 3 (March 2007), 445-8.

<sup>19</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 910. Yokana Muwereza admitted May 4<sup>th</sup>, 1915; *Oxford English Dictionary*, 3<sup>rd</sup> ed., s.v. “papule.”

<sup>20</sup> Eva Brehmer-Andersson, “Syphilis,” in *Dermatopathology* (Verlag: Springerlink, 2006), 116.

<sup>21</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 905. Daudi Sempa admitted May 3<sup>rd</sup>, 1915.

expanding ulcers.<sup>22</sup> In Sempa's case these ulcers clustered around his feet, inhibiting his ability to walk. Tertiary syphilis presented in other patients at Mengo Hospital, like Matias Mwanga, a Roman Catholic, as aches in the body, as the bacteria colonized and ate their way through bone and nerves.<sup>23</sup> These patients might suffer chronic pain, disfigurement, and death.

Occasionally, families brought newborns and infants suffering from congenital syphilis to Mengo Hospital. Such was the case with Kibirige, who was examined in 1921. Cook noted, "M[other] has had 5 children—3 dead in infancy, 1 alive. Present infant no. 5 [sic]. The M[other] shows signs of an old necrosis of the vault of the skull. [Kibirige's f]ace + head pretty well covered in annulated [ringed] sores."<sup>24</sup> According to Cook, cases like these with strings of miscarriages and early deaths were far too common.<sup>25</sup> For Cook and the other doctors at Mengo Hospital, symptoms like those presented above—genital sores, scaly, papular rashes, infected foreskins and swollen genitals, gummata, aching bones, and strings of miscarriages—were all attributable to syphilis.

To Baganda, however, these symptoms could indicate *kabotongo*, a condition similar to, but distinct from, syphilis, and more akin to yaws. According to my informants, including several youth counselors of various religions, ethnicities, and both genders working at a President's Emergency Plan for AIDS Relief (PEPFAR) clinic in Wakiso District, and Fatuma Namusoke, a Muslim, female gynecologist and obstetrician working at Mulago

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<sup>22</sup> Joseph Coats, *A Manual of Pathology*, 5<sup>th</sup> ed. (London: Longmans, Green and Co., 1903), 180-2.

<sup>23</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, 1912. Matias Mwanga admitted November 7<sup>th</sup>, 1921.

<sup>24</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, 2184. Kibirige admitted November 15<sup>th</sup>, 1921.

<sup>25</sup> A.R. Cook and K. Cook, "The Population Problem in the Uganda Protectorate: A Suggested Remedy," *The Uganda Herald*, December 13, 1918, 14.

Hospital, while *kabotongo* is associated with syphilis, general body pains are also described as *kabotongo*.<sup>26</sup>

Meanwhile, there are many types of *kabotongo*. The 1913 Law of Dangerous Diseases, *Etteka Ku Ndwadde Embi Ezikwata*, lists ten types of *kabotongo*:

*Kabotongo ow'engeri zino*: [these types of *kabotongo*]

1. *Kabotongo ow'embeteza* [kabotongo of the genitals]
2. *Kabotongo ow'akachuchuke* [congenital kabotongo]
3. *Kabotongo ow'ebikwera* [leprosy like kabotongo]
4. *Kabotongo ow'ekikindu*
5. *Ennungu ez'olutentezi* [relapsing fever]
6. *Kiyindi* [possibly a description of a symptom like swollen glands looking like]
7. *Munnyu* [salty sores]
8. *Amabwa g'omu nkwawa, ku mimwa, mu bulago* [sores in the mouth, armpits, and throat]
9. *Amabwa ag'omu lubugo* [stomach ulcers]
10. *Lwekika* [joint stiffness]<sup>27</sup>

*Kabotongo*, thus, to the Baganda is not a single disease with a single causative agent, but more of a general “malady,” to use Hardiman’s term for Sub-Saharan African conceptions of illness.<sup>28</sup> Therefore, while *kabotongo* is often translated as and equated to syphilis, this equivalence ignores the more expansive conception of disease captured by the term, *kabotongo*.

Moreover, while Europeans stigmatized syphilis as a disease of moral degeneracy, ethnographic research suggests that Baganda did not view *kabotongo* in moral terms. Davies, a Professor of Pathology at Makerere Medical School, noted in 1947: “[T]here was no stigma attached to ‘kabotongo’, and ... it was probably regarded as a non-venereal disease, and ...

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<sup>26</sup> Campi Ritah, interview by author June 28, 2011; Mugoya Alisat, interview by author, June 28, 2011; Julius Mutebe, interview by author, June 28, 2011; Jack Kekwangire, interview by author, June 28 2011; Joshua Kiwumulo, interview by author, June 28, 2011; Fatuma Namusoke, interview by author, June 16, 2011.

<sup>27</sup> Apollo Kaggwa, Stanislas Mugwanya, and Z. Kizito Kisingiri, *Etteka Ku Ndwadde Embi Ezikwata* trans. Robinson Kisaka and Namai Michael (June 6, 1913). Some of these terms were too antiquated or specialized even for University and Medical School educated native Luganda speakers to understand.

<sup>28</sup> David Hardiman, “Introduction,” in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, ed. David Hardiman (Amsterdam Rodopi, 2006) 36.

only in recent years were modern educated people in Buganda realizing that there was any social opprobrium attached to syphilis.”<sup>29</sup> Colonialists likewise noted with dismay the lack of stigma attached to either syphilis or *kabotongo* by the Baganda. The East Africa Commission blamed Ganda moral naïveté for the disease’s dissemination: “The main trouble has been that no social stigma was attached to the disease and that native public opinion regarded catching it sooner or later as inevitable.”<sup>30</sup>

Beyond that, venereal disease actually conferred distinction, at least for upper class Baganda. Jack Cook, Albert Cook’s younger brother, noted “*Abaganda balowozanga nti omuvubuka tanaba kukula singa yali tanahwala ndwade ya bukaba* [The Baganda believe that a boy is not yet a man until he is infected with a venereal disease.]”<sup>31</sup> The literature suggests that Kabaka Mutesa, the King of Buganda from 1856 to 1884, made venereal disease a mark of virility when he contracted gonorrhea and composed the following song: “*Atalina nziku mugwagwa, Atalina nziku mudembe*. [He without gonorrhea is a fool, He without gonorrhea is a coward.]”<sup>32</sup> Indeed, during my research in Uganda, a Medical School student at Makerere University, Fatuma Namusoke, told me that if I went to the neurological ward, I could find tertiary syphilis patients who would boast that they had “the disease of the brave.” Many Baganda, therefore, interpreted either syphilis or *kabotongo* in a fashion that was not only alien, but offensive, to the sensibilities of English, Protestant missionaries at Mengo Hospital.

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<sup>29</sup> J.N.P. Davies, “The History of Syphilis in Uganda,” *Bulletin of the World Health Organization* 15 (1956): 1048.

<sup>30</sup> Secretary of State to the Colonies. *Report of the East Africa Commission*. 1925 Cmd. 2387, 144.

<sup>31</sup> J.H. Cook *Okufa Okwabana Mu Buganda Bwekuli* trans. Robinson Kisaka (1908), ACML.

<sup>32</sup> John A. Rowe, “Revolution in Buganda 1856-1900,” (PhD diss., University of Wisconsin, 1966), 49. Indeed, during my research in Uganda, a Medical School student Makerere University, Fatuma Namusoke, told me that if I went to the neurological ward, I could find tertiary syphilis patients who would proudly tell me that they had “the disease of the brave.”

In addition, Baganda related *Kabotongo* sickness to spiritual and social causes. In his observations regarding Ganda conceptions of health Billington observed that: “such disease [socially and spiritually implicated disease] does not conform to a clear Western diagnosis and cannot be cured through Western medicine.”<sup>33</sup> Thus, patients at Mengo sought care for conditions that biomedicine recognized as syphilis. But these patients had their own interpretations of the nature and cause of their suffering. As John Janzen has observed, disconnection between European and African concepts of sickness led to mutual misunderstanding, distrust, and ambivalence.<sup>34</sup>

## Kin

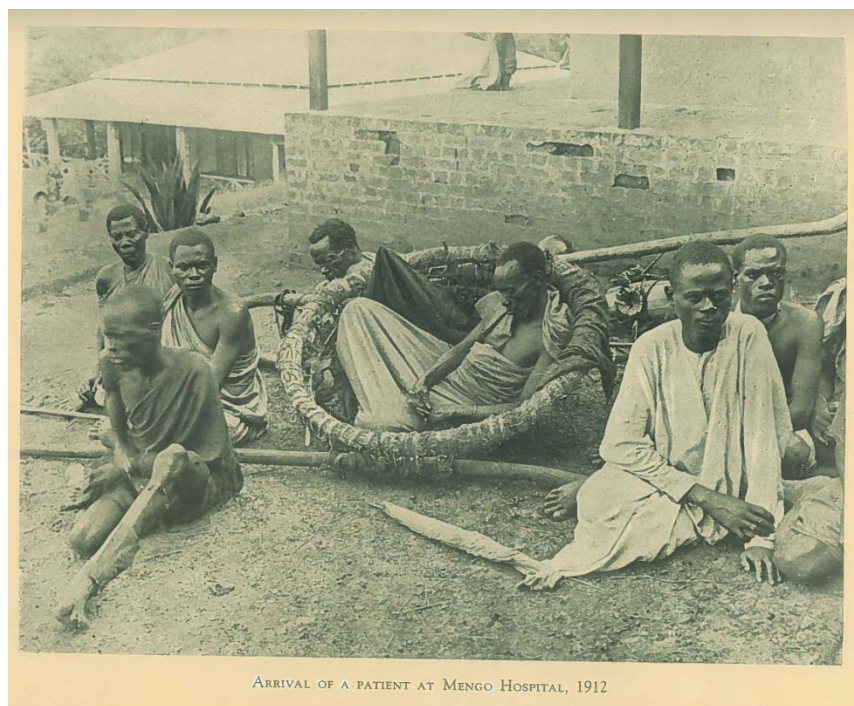


Image 8: Sick Patient Carried to Mengo Hospital<sup>35</sup>

<sup>33</sup> W.R. Billington, “Interpersonal Relationships in Medicine,” *Albert Cook Memorial Lecture, 1965* (1965), 158. I found this source stored away on a shelf in the ACML.

<sup>34</sup> David Hardiman, “Introduction,” in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, ed. David Hardiman (Amsterdam Rodopi, 2006) 36; J Janzen, *The Quest for Therapy in Lower Zaire* (Berkeley: University of California Press, 1978), 52.

<sup>35</sup> “Arrival of a Patient at Mengo Hospital, 1912,” in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 228.

The scholarship on medicine in Sub-Saharan Africa illustrates the tremendous importance of kin in therapeutic practices. Janzen illustrated that in the Congo the care and management of a sick person became the collective responsibility of a kin “therapy management group.” He wrote: “Various maternal and paternal kinsmen, and occasionally their friends and associates, rally for the purpose of sifting information, lending moral support, making decisions, and arranging details of therapeutic consultation.”<sup>36</sup> Janzen’s findings apply to Albert Schweitzer’s Lutheran missionary clinic in Gabon, which was intentionally kept in unsanitary conditions that European observers described as “horrible.” Schweitzer’s rationale was simultaneously insightful and condescending: that unsanitary conditions mirrored village life, thus making the hospital more like home for the family members accompanying patients. Leaving aside the rather casual racism informing this logic, Schweitzer clearly recognized the importance of kin and the existence of a “therapy management group.”<sup>37</sup> Many other investigations, including Langwick’s work in modern Tanzania, also indicate that therapy management groups existed throughout Sub-Saharan Africa during the colonial era, and have endured through the introduction and institutionalization of “modern” biomedicine.<sup>38</sup>

As noted above, however, the role of kin is obscured in Mengo case notes. Indeed, the Mengo records suggest that the missionary doctors at Mengo Hospital actively sought to separate patients and their care from the influence of kin. Cook blamed “witch-doctors,” and “native medicine,” for causing more maternal mortality than another other factor. He noted

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<sup>36</sup> J Janzen, *The Quest for Therapy in Lower Zaire* (Berkeley: University of California Press, 1978), 4; J Janzen, “Therapy Management: Concept, Reality, Process,” *Medical Anthropology Quarterly* 1, no. 1 (March, 1987): 68-84.

<sup>37</sup> Rita Headrick, *Colonialism, Health, and Illness in French Equatorial Africa 1885-1935* (Atlanta: African Studies Association Press, 1994), 265; *Le grand blanc de Lamaréné* (2005), DVD, Directed by Bassek Ba Kobhio. San Francisco: California Newsreel, 2005).

<sup>38</sup> Stacey Langwick, “Articulate(d) bodies: Traditional medicine in a Tanzanian hospital,” *American Ethnologist* 35, no. 3 (2008): 428-439.

with dismay: “Few of the younger women, except those who have better educated husbands, are fortunate enough to escape the ignorant attractions of the old woman of the village.”<sup>39</sup>

Cook’s vehemence in thus castigating “native medicine” underlines, paradoxically, the importance of traditional therapy management groups in Ganda responses to illness. Cook’s aspersions also evidence and justify the ambivalence and circumspection with which the Baganda viewed missionary and biomedical treatment.

Other sources also make clear that kin went to great lengths to provide care for Baganda patients, and sometimes to shelter them from medical authorities. In a puff piece for the hospital, Cook described husbands bicycling to Mengo Hospital with their pregnant wives riding on the back, or rousing chiefs and villagers to get men to help carry their wives 20 to 30 miles for treatment at Mengo during labor.<sup>40</sup> Cook also described kin seeking pre-natal treatment for syphilis, referring to husbands making “a journey of many miles to obtain the valued drug [a compound provided at Mengo Hospital for syphilis treatment] for their wives who are unable to walk the distance.”<sup>41</sup> While Cook’s self-promotion should be taken with a grain of salt, his observations about the role of family members getting their kin to Mengo for treatment shows that at least some Baganda turned to Cook and the hospital staff for the care of their wives and the reproduction of their lineages.

In other circumstances, “therapy management groups” avoided the biomedical attention of the state. George Keane reported with dismay in 1921 that female attendance at government clinics was disproportionately low compared to that of men. Total female attendance at the government’s venereal clinic, Mulago Hospital, was only 27% that year,

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<sup>39</sup> A.R. Cook, “Recent History” Incoming General Correspondence 1923-30, Mengo Hospital Papers, ACML.

<sup>40</sup> A.R. Cook, “Recent History” Incoming General Correspondence 1923-30, Mengo Hospital Papers, ACML.

<sup>41</sup> A.R. Cook, *The Treatment of Ante-Natal Syphilis in Buganda Women*, delivered to the UBBMA on March 22, 1929.



despite the fact that the hospital had taken on a female physician, Margaret Lamont, to attract more female patients. Keane concluded that several factors conspired to keep females away, including their numerous and onerous domestic obligations, which made it difficult to seek treatment.<sup>42</sup> He also posited that “many of the female infected are being shielded by their relatives, and probably also by the chiefs, from the beneficent efforts of anti-venereal treatment.”<sup>43</sup>

Although most Baganda did not record reservations they may have had about attending Mengo Hospital, their actions reflected in Mengo records suggest that many preferred to avoid biomedicine, and only turned to Mengo as a last resort. Thus patients and their kin waited weeks before seeking treatment there. Eseza Nsungi’s mother, for example, did not bring her child to Mengo until a week after a rash erupted on Nsungi’s head. Lalska Bangiasbero’s kin similarly waited a week: “one week ago pt. had a rash which came out on the vulva.” Some patients waited considerably longer. Yokana Muwerezza only came to Mengo a month after he noticed a sore on his foot. Similarly Malyrni Gwoloraba suffered from sores on her vulva for roughly a month before finally deciding to seek treatment at

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<sup>42</sup> G.J. Keane, “Appendix No. III: Annual Report on Venereal Disease Measures: Uganda for 1921,” in *Annual Medical and Sanitary Report for the Year Ended in December 31<sup>st</sup>, 1921* (Entebbe: Government Printer, 1922): 67.

<sup>43</sup> G.J. Keane, “Appendix No. III: Annual Report on Venereal Disease Measures: Uganda for 1921,” in *Annual Medical and Sanitary Report for the Year Ended in December 31<sup>st</sup>, 1921* (Entebbe: Government Printer, 1922): 67. Keane, writing candidly to his superiors, may provide a more accurate account than Cook’s of how kin safeguarded their women from genital examinations. On the other hand, Keane’s observations may also reflect the conditions at Mulago Hospital rather than Mengo. Mulago Hospital forced women to undergo examination. Although Keane maintained that “Examinations are not a prominent part of this work and occupy only a minor position in it,” Margaret Lamont, Mulago’s only female physician, resigned in protest of the coercive measures, setting off demonstrations in England. Lamont declared “I found I was called upon to assist in working venereal disease laws and regulations [... that] apply to the whole native population; they involve the compulsory examination and treatment of whole villages of people and this at regular intervals.” If patient kin made the distinction between the coercive measures at Mulago and male administrated genital exams at Mengo is an open question. G.J. Keane, “Appendix No. III: Annual Report on Venereal Disease Measures: Uganda for 1921,” in *Annual Medical and Sanitary Report for the Year Ended in December 31<sup>st</sup>, 1921* (Entebbe: Government Printer, 1922): 68; Carol Summers, “Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925,” *Signs* 16, no. 4 (Summer, 1991): 801; Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 258.

Mengo Hospital. What did these patients and their kin do in the time between when symptoms first appeared and when they sought biomedical treatment?

First, it appears that patients and kin often sought out traditional medicine for a relative, before turning to a European hospital. These medical rituals included religious rites:

The suppliant would do as he had been bidden. He would make beer and build a special temple for the gods. Then he would bring the sick person near and begin to pray....A chicken feather and a small piece of goat skin and barkcloth were used in place of the actual offerings because the temple was small and for private use only. At the end of this prayer he poured beer on the ground and said, 'Have mercy upon this sick person.'<sup>44</sup>

Charms were also used to cure: "*Okulumika*. To bleed by cupping. This was done by the diviners. One would come to a very sick person and say that he was being charmed; that he would work a cure at the price of a goat."<sup>45</sup> Preventative treatments were also employed, including spells and charms, but also techniques such as vaccination for *kabotongo*.

Lambkin, who popularized the syphilis outbreak, noted with revulsion:

I had heard rumours [sic] of a practice which was said to exist in some of the provinces of deliberate vaccination of healthy infants with the syphilitic virus from affected persons, the reason given for the practice being that syphilis communicated in this way during infant life conferred immunity from it to the adult....Investigation proved that this dreadful state of things does exist.<sup>46</sup>

As might be expected, British medical professionals took note of and resented the Baganda's use of popular medicine. Hospital Assistant V.R. Lande, working for the Protectorate in Makasa, reported in 1908: "[T]he aggravated stages of these venereal diseases as I have already pointed out, is due to the fact that the patients do not present themselves for treatment in the earlier stages, except when their own native medicines fail to effect any

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<sup>44</sup> Apolo Kagwa, Ernest B.E.M. Kalibala, John Roscoe, *The Customs of the Baganda* (New York: Columbia University Press, 1934), 125.

<sup>45</sup> *Ibid.*, 128.

<sup>46</sup> F.J. Lambkin, "An Outbreak of Syphilis on Virgin Soil," in *A System of Syphilis*, ed. D'Arcy Power (London: Oxford University Press, 1908), 2: 347.

cure.”<sup>47</sup> Cook’s case notes, which reported evidence that patients had received “native” medicine, confirmed this pattern. When Sala Gwaliwa attended Mengo Hospital, Cook noted: “Patient was saturated with Kiganda [the way of the Baganda] medicine.”<sup>48</sup>

At the same time, however, that Ganda medicine attracted patients leery of attending European clinics, it appears that European drugs held allure. Thus, some patients and kin acquired European medicine from Baganda merchants to avoid the expense, time, and indignities associated with a hospital stay.<sup>49</sup> Patients and medical assistants stole from Mengo Hospital to supply the demand for European medicine without a hospital visit. As a result, according to Kalibala, in the 1910s, village pharmaceutical “[b]usiness picked up and the sale of venereal disease remedies skyrocketed.”<sup>50</sup> The growth of this “grey market,” which often operated on the borders of legality, emphasizes that Baganda chose what elements of biomedicine to use: European drug remedies were desirable, while European treatments often were not.<sup>51</sup>

## Society

The ambivalence that “therapy management groups” felt with regard to biomedical treatment: simultaneously wishing to provide kin with biomedical resources, and to shelter

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<sup>47</sup> V.R. Lande, “Annual Medical Report of Masaka for 1908” in *Annual Medical and Sanitary Report for the Year Ended in December 31<sup>st</sup>, 1908* (Entebbe: Government Printer, 1909): 107. Lande appears to have been too honest about how “natives” viewed colonial treatments. The next sentence read, “It has been reported that many natives of this district affected with Sleeping Sickness have slipped away in order to escape the supposed terrors.” This sentence was crossed out of the final report.

<sup>48</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 1064. Sala Gwaliwa admitted September 5<sup>th</sup>, 1915. *Kiganda* means “the way the Baganda do things”

<sup>49</sup> Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 242-3.

<sup>50</sup> *Ibid.*, 249-50; Ernest Balintuma Kalibala, “The Social Structure of the Baganda Tribe of East Africa” (PhD diss., Harvard University, 1946), 512. I am indebted to Tuck for this reference.

<sup>51</sup> Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 248-51. Whyte found the same phenomena in her study of the privatization of healthcare following neoliberal structural adjustments in Uganda. Susan Reynolds Whyte, “Pharmaceuticals as Folk Medicine: Transformations in the Social Relations of Health Care in Uganda.” *Culture, Medicine and Psychiatry* 16 (1992): 163-186.

them from its pains and indignities, reflected and reinforced other ambiguities that played themselves out on the social stage. However, while the decisions and judgments made at the kin therapy level concerned the effectiveness and the quality of care for a relative, societal ambivalence over European anti-venereal efforts reflected deeper concerns about colonialism.

Colonial processes plunged the Kingdom of Buganda into a deep social and moral crisis. Starting during the era of informal empire in the 1870s, the Baganda underwent, in Karlström's phrase, the "Christianization of social reproduction."<sup>52</sup> Zealous missionaries convinced many Baganda of the material and spiritual desirability of embracing the Christian faith. However, conversion entailed the loss of important Ganda traditions. Missionaries not only campaigned against polygamy, but also showed little tolerance for the *kwabya lumbe* ceremony, which "enacts an idealized image of the social totality and moral community" of the Baganda.<sup>53</sup> Missionary campaigns against these and other cultural practices destabilized the Kingdom of Buganda's social order.

At the same time, land reforms also entrenched missionary efforts against the social reproduction of precolonial, "heathen" Ganda culture. The Buganda Agreement of 1900 distributed large tracts of land to the King of Buganda, the *kabaka*, and to his major, usually Christian, chiefs. Non-Christian chiefs received little in terms of land, ensuring their economic and political marginalization. Moreover, the *mailo* system introduced in the Buganda Agreement of 1900 established massive inequalities between the Baganda

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<sup>52</sup> Mikael Karlström, "Modernity and Its Aspirants: Moral Community and Development Eutopianism in Buganda," *Current Anthropology* 45, no. 5 (December, 2004): 600.

<sup>53</sup> *Ibid.*

peasantry, the *bakopi*, and the new landed elite, further eroding precolonial patron-client relations of social support and reciprocal obligation.<sup>54</sup>

Alarm about this degradation of the traditional social order found expression in concern over female mobility and sexual immorality.<sup>55</sup> Thus studies of syphilis and venereal disease in Uganda have focused on how the Baganda male elite exploited colonial anxieties about venereal disease to exert control over Baganda women. Tuck, in particular, argues that the Kingdom of Buganda's governing body, the *lukiiko*, relied on syphilis as "the justification for legal measures to control women."<sup>56</sup> Tuck is certainly correct that the idea of female autonomy worried the Kingdom of Buganda's male elite, but he fails to attend to other Ganda voices, particularly the *bamalaki*, an anti-colonial religious sect, in interpreting how Baganda reacted to European anti-venereal efforts. Adding those voices reveals that the Baganda social discourse about these efforts masked a political debate over the control British colonizers should have over the Kingdom of Buganda. The Baganda male elite supported anti-venereal efforts because they were anxious about female autonomy, but also because anti-venereal legislation increased their authority over their subjects, though still in the context of indirect rule. In contrast, the *bamalaki* opposed the European anti-venereal campaign not only because it intruded into the most intimate and important aspects of society—sexuality and reproduction—but also because they objected more generally to colonial rule.

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<sup>54</sup> Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 144-50; Holly Elizabeth Hanson, *Landed Obligation: The Practice of Power in Buganda* (Portsmouth, NH: Heinemann Books, 2003).

<sup>55</sup> Mikael Karlström, "Modernity and Its Aspirants: Moral Community and Development Eutopianism in Buganda," *Current Anthropology* 45, no. 5 (December, 2004): 601.

<sup>56</sup> Michael William Tuck, "Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda" (PhD diss., Northwestern University, 1997), iv.

Female mobility and sexuality certainly dismayed an educated, Christian male segment of Baganda society. The Baganda male elite fretted about prostitution, particularly about Baganda female prostitutes operating outside of Buganda. White relates that two scandalized young Christian Baganda men wrote to colonial officials denouncing the prevalence of Baganda prostitutes in Nairobi.<sup>57</sup> Ganda men also expressed outrage about “*Bamalaya Abaganda eNairobi* [Baganda prostitutes in Nairobi]” in Luganda-language newspapers. In 1918, one contributor to the *Ebifa mu Buganda*, a CMS-supported Protestant newspaper, Temusewo B. Mukasa, declared:

*ya tugenze okulaba nga abakyala bangi bava eBuganda mu biro bino nga  
baja munsi eno; songa akatale ako kali kakendedeko bewbawulira ekigambo  
ekyoknbaza eBuganda*

[Many women now leave Buganda to become prostitutes, though in the past this was discouraged, now nothing can stop them; ladies and gentlemen, this news is not good for our beloved country, Buganda, to hear.]<sup>58</sup>

On one level, Mukasa’s article reflects unease with a degradation of the apparatus of moral control. Importantly, however, Mukasa, like his contemporaries, is really concerned about how these prostitutes reflect on the Kingdom of Buganda’s national character, rather than on what conditions conspired to motivate Baganda women to sell their bodies in Nairobi.

Between the lines, Mukasa argues that colonial developments have struck a blow to Ganda integrity.

This Christian, literate male elite expressed worries about colonial opportunities for women “unleashing” female sexuality in relationship to the spread of syphilis. The *katikiro*, Sir Apolo Kagwa, for example, expressed dismay at the disappearance of precolonial sexual prohibitions and restraints on female mobility and sexuality. Lambkin, in his sensational

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<sup>57</sup> Luise White, *The Comforts of Home: Prostitution in Colonial Nairobi* (Chicago: Chicago University Press, 1990), 68-73.

<sup>58</sup> Temusewo B. Mukasa, “*Bamalaya Abaganda eNairobi*,” *Ebifa mu Buganda* (July, 1918).

report on syphilis in Uganda, noted that Kagwa, “the very enlightened native Prime Minister, remarks: ‘The probable immediate cause of the outbreak was the emancipation of the Baganda women from the surveillance to which they had hitherto been subjected.’”<sup>59</sup> That Kagwa presented female sexual liberation as a significant danger to a society in which polygamy, chiefs possessing concubines, and the practice of *bahuma*—sharing wives amongst clansmen—were the prevalent sexual practices, and sexual violence, including raping children, was rampant, according to Kuhanen, certainly casts doubt on the validity and sincerity of Kagwa’s assessment.<sup>60</sup> This is especially so since his argument about female sexual liberation is also an implicit argument in favor of indirect rule. Kagwa, a devout Protestant, and a Knight Commander in the Order of St. Michael and St. George (KCMG), held a key position as the regent and Prime Minister in implementing British colonial rule. He also owed his political rise to the system of indirect rule.<sup>61</sup> His position—that the disruption of “traditional” modes of control over women created a syphilis epidemic—in effect protected his “turf” as an intermediary between the British overlords and the Baganda, in effect warning that direct British rule would lead to a further breakdown of society.

Tuck asserts that the Dangerous Disease Act of 1913 was enacted by the Kingdom of Buganda’s ruling male elite to reassert control over women. The statute allowed the County Chief (*saza*) to make people suffering from venereal disease submit to medical treatment:

*[o]w’essaza alina obuyinza okulagiranga alwadde endwadde eyo  
okuninanga eddagala ew’omusawo, oba okusulira ddala gye bawera  
eddagala*

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<sup>59</sup> F.J. Lambkin, “An Outbreak of Syphilis on Virgin Soil,” in *A System of Syphilis*, ed. D’Arcy Power (London: Oxford University Press, 1908), 2: 345.

<sup>60</sup> Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 294.

<sup>61</sup> John Parker and Richard Rathone *African History: A Very Short Introduction* (Oxford: Oxford University Press, 2007), 102.

[Furthermore, the *saza* has the authority to command anyone suffering from the aforementioned venereal diseases to seek medicine at a Hospital, or to be admitted to the hospital.]<sup>62</sup>

Since the Luganda language has no gendered pronouns, the statute is not gender-specific; however, only male elites drafted the legislation, and Tuck's conclusion that controlling female bodies was a key part of the law's impetus seems valid.<sup>63</sup> In addition, other legislation written in the same vein as the Dangerous Disease Act of 1913, such as the Adultery and Fornication Law of 1917, indicates that the Baganda parliament (*lukiiko*) followed a legislative agenda directed towards curbing female autonomy and mobility.

But the law should also be viewed in the larger context of claims about British colonial rule.<sup>64</sup> It was not solely a product of Baganda inspiration, since colonial officials requested its enactment.<sup>65</sup> Keane reported to the Protectorate's PMO that his main accomplishment for 1913 was "preparation and promulgation of the native law for ensuring compulsory attendance for treatment of contagious venereal disease."<sup>66</sup> Thus, the Dangerous Disease Act of 1913 was a product of indirect rule as much as a Baganda male effort to

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<sup>62</sup> Apollo Kaggwa, Stanislas Mugwanya, and Z. Kizito Kisingiri, *Etteka Ku Ndwadde Embi Ezikwata* trans. Robinson Kisaka (June 6, 1913). Kaggwa and the *lukiiko* modeled the Dangerous Disease Act of 1913 on the Mid 19<sup>th</sup> Century English Contagious Disease Acts. In an effort to reduce venereal disease, the Contagious Disease Acts allowed a police officer to arrest women whom he considered to be prostitutes. The acts incited intense feminist opposition that eventually resulted in their repeal. Margaret Hamilton, "Opposition to the Contagious Disease Acts, 1864-1886," *Albion: A Quarterly Journal Concerned with British Studies* 10, no. 1 (Spring, 1978): 14-27.

<sup>63</sup> Apollo Kaggwa, Stanislas Mugwanya, and Z. Kizito Kisingiri, *Etteka Ku Ndwadde Embi Ezikwata* trans. Robinson Kisaka (June 6, 1913); Michael William Tuck, "Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda" (PhD diss., Northwestern University, 1997), 128-9.

<sup>64</sup> Michael William Tuck, "Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda" (PhD diss., Northwestern University, 1997), 126-130.

<sup>65</sup> Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," *Signs* 16, no. 4 (Summer, 1991), 793.

<sup>66</sup> G.J. Keane, "Appendix No. III: Annual Report on Venereal Disease Measures: Uganda for 1913," in *Annual Medical and Sanitary Report for the Year Ended in December 31<sup>st</sup>, 1913* (Entebbe: Government Printer, 1914): 78.



reverse female sexual emancipation. Overall it seems to reflect a happy alignment of interests, and consequent cooperation, between these two centers of power.<sup>67</sup>

The Baganda Parliament (*lukiiko*) having enacted the Dangerous Disease Act of 1913, however, regional chiefs (*saza*), sub-regional chiefs (*gombolola*) and the Baganda peasants (*bakopi*) seem not to have worked hard to enforce it. Keane reported: “No legal proceedings of any kind have been taken under any of the legal enactments.”<sup>68</sup> This suggests that while the male elite comprising the *lukiiko* may have countenanced compulsory medical examination and treatment of Baganda men and women, much of the rest of Baganda society was unwilling to comply with the law and passively resisted it.

Some Baganda actively resisted colonial biomedical imposition. The *bamalaki* religious sect was named for its founder, Malaki Musajakawa, who broke away from the Native Anglican Church (NAC) in 1913, though its adherents referred to themselves as “*Katonda Omu Ainza Byona* [The Society of the One Almighty God].”<sup>69</sup> The group grew rapidly and gained astonishing popularity from its founding until 1929. Cook reported that as many as 2,400 converts were baptized in one day.<sup>70</sup> By 1921, eight years after its creation, the group had as many as 91,000 to 110,000 followers.<sup>71</sup>

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<sup>67</sup> The *lukiiko*'s compliance with the legislation is telling though: the *lukiiko* willingly enacted a law that gave colonial medical officers and missionaries the right of compulsory examination and treatment of the Baganda.

<sup>68</sup> G.J. Keane, “Appendix No. III: Annual Report on Venereal Disease Measures: Uganda for 1921,” in *Annual Medical and Sanitary Report for the Year Ended in December 31<sup>st</sup>, 1921* (Entebbe: Government Printer, 1922): 66. The legal enactments other than the Dangerous Disease Act are the Venereal Rules of 1913, the Dangerous Disease Ordinance of 1909 and 1913, and the Township (Venereal) Rules of 1913. These are colonial initiated legislation. Carol Summers, “Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925,” *Signs* 16, no. 4 (Summer, 1991), 793.

<sup>69</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 323.

<sup>70</sup> *Ibid.*, 324.

<sup>71</sup> Luise White, “‘They Could Make Their Victims Dull’: Genders and Genres, Fantasies and Cures in Colonial Southern Uganda,” *The American Historical Review* 100, no. 5 (December, 1995): 1396; Ben Jones, *Beyond the State in Rural Uganda* (Edinburgh: Edinburgh University Press, 2008), 118.

The sect was organized around the tenet that medical treatment defied God's will.<sup>72</sup>

This tenet was based on a verse from Deuteronomy:

Thou shalt not learn to do after the abominations of those nations. There shall not be found with thee anyone that maketh his son or daughter to pass through fire, or that useth divination, or that practiseth augury, or an enchanter, or a sorcerer, or a charmer (*omusawo* [doctor]), or a consulter with familiar spirit, or a wizard or necromancer.<sup>73</sup>

Though in theory the proscription applied equally to Ganda and European medicine, the reference to the “abominations of *those* nations,” and the translation of “charmer” as *omusawo*, the word used for European doctors, indicate that the *bamalaki* focused on European medicine as an affront to God. Accordingly, inductees vowed: “I will not drink the European's medicine or go to them for any....”<sup>74</sup> Missionary sources indicate that the *bamalaki* also took a hard line against Salvarsan, a treatment for syphilis known as “606”, because they associated it with “666”, the Devil's number.<sup>75</sup> This notion invites skepticism, but the *bamalaki* certainly engaged in acts of violence against European medical practitioners. A gang of *bamalaki* went so far as to attack, and to amputate the fingers of, a European Sanitary Inspector:

*Omuzungu Mr. Kendall Omulambuzi w'ebya Kawumpuli yalumbibwa Aba-Malaki mu Bulemezi. Omukono gw'Omuzungu gwatemebwa mukiseke ne gusigala kalebwerebwe.*

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<sup>72</sup> Luise White, “‘They Could Make Their Victims Dull’: Genders and Genres, Fantasies and Cures in Colonial Southern Uganda,” *The American Historical Review* 100, no. 5 (December, 1995): 1396; A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 323.

<sup>73</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 323.

<sup>74</sup> Luise White, “‘They Could Make Their Victims Dull’: Genders and Genres, Fantasies and Cures in Colonial Southern Uganda,” *The American Historical Review* 100, no. 5 (December, 1995): 1396.

<sup>75</sup> *Ibid*; Michael William Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 238; for further discussion of Salvarsan see Chapter Three: Treatment.

[A white man, Mr [sic] Kendall, who treats smallpox was attacked by the Malakites in Bulemezi. All the fingers of the white man's hand were cut off.]<sup>76</sup>

The symbolism of this brutal act is clear: cutting off Kendall's fingers ensured that he would no longer administer smallpox inoculations. In other words, the act was aimed at European biomedical interference. In response, the Protectorate Government exiled Musajakawa, and the group's popularity dropped rapidly.

*Bamalaki* resistance to European intervention of all kinds, and most certainly to anti-venereal efforts, contrasts with the attitude of the Baganda male elite, which was quite thoroughly invested in the system of indirect rule. The divergent attitudes of these groups show that the access that white doctors (*musawo musungu*) should have to Baganda bodies, the proper "place" of women, and who should control reproduction, were not settled matters. Further, the broad popularity of the *bamalaki*, and the fact that the Dangerous Disease Act of 1913 was treated as little more than a dead letter, indicates that regardless of the meaning the Baganda derived from, or the value they placed on, biomedical treatment, significant numbers of people resented the overbearing nature of colonial medical care.

### ***European Patients***

Europeans suffering from venereal diseases during this period did not evince this kind of ambivalence or antipathy. Unlike Baganda patients, these patients largely grew up in the same British medical culture that informed their medical treatment, and were familiar with their missionary doctor's perception of syphilis's etiology—and with its social stigma. Without question, these patients saw no alternative to biomedical care, so there was no decision to be made about where to seek treatment while in Uganda. Finally, these patients

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<sup>76</sup> "Aba-Malaki," *Ebifa mu Buganda*, trans. Robinson Kisaka August 1929; A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 324.

did not face the challenge of either accepting or opposing an aspect of colonial subordination in receiving treatment at Mengo Hospital.

These distinctions are manifest in letters from European patients, which portray a very different interaction with the hospital from that of the Baganda. As opposed to most African patients, a fairly large number of white patients corresponded with their doctors, setting up appointments, arranging for treatment, and divulging intimate details about their lives. J.M. Lollyn, a Protectorate official passing through Kampala, wrote to Dr. Sharpe at Mengo Hospital: “I am writing to ask you whether you can arrange to give me my 2<sup>nd</sup> injection of Salvarsan tomorrow afternoon or Sunday.”<sup>77</sup> W. Morris, possibly the Protectorate Judge, wrote: “I regret that I have to write you on a rather indelicate subject.... Send with bearer either medicine or instructions to effectively stop the matter oozing—It is not gonorrhoea [sic] as the symptoms are not at all similar.”<sup>78</sup> The writers of these letters trusted the missionary doctors they were addressing, both to provide the best available cures, and to be discreet. In addition, Morris’s defensiveness and obvious embarrassment highlights that Morris, unlike some Baganda, stigmatized venereal infection. J.C. Nunes also wrote to Cook:

I have several times [had] intercourse with native girls and consequently had a sore some months back—this was treated and cured by Dr. Stone (with injections etc).... After treatment—I have not committed [the] same sins again and suffer while passing urine.<sup>79</sup>

That Nunes returned to Mengo for treatment and that he called his sexual relations sins demonstrates a European cultural vocabulary about syphilis that Baganda patients did not

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<sup>77</sup> J.M. Lollyn to Sharpe, March 26, 1915, Incoming Correspondence, 1913-1914, Letter Box 2, Mengo Hospital Papers, ACML.

<sup>78</sup> W. Morris to A.R. Cook, November 31, 1907, Incoming Correspondence 1899; 1900-1914, Mengo Hospital Papers, ACML.

<sup>79</sup> J.C. Nunes to A.R. Cook, June 30, 1919, Incoming General Correspondence 1919-1921; 1925-30; 1917-1931, Mengo Hospital Papers, ACML.

share. Finally, Nunes' trust in and deference towards Cook further illustrates a different kind of relationship from that between European doctors and Baganda patients.

### **Conclusion**

This chapter shows that Baganda had their own understanding of an illness category, *kabotongo*, for diseases that biomedical doctors diagnosed as syphilis and yaws. This Ganda understanding did not mesh well with Western conceptions of the cause and nature of disease. Furthermore, kin therapy management groups, while sometimes seeking biomedical cures, were likely to be reluctant to subject their kin to missionary and colonial scrutiny and coercion. Such ambivalence found its way into social discourse over female mobility, which also was concerned with the appropriate extent of colonial rule. In contrast, European patients were not subject to this ambivalence, indicating that race and racialized care had a role in Ganda ambivalence. Next I examine treatment, and see how this ambivalence became manifest in the clinic.

### CHAPTER THREE: TREATMENT



Image 9: Katharine Cook Dispensing Medicine while on Safari<sup>1</sup>

Let's continue with Lulyatumanyi's story. After diagnosing her with syphilis and admitting her to Mengo Hospital, Cook turned his attention to her treatment. Lulyatumanyi's pregnancy and the effect syphilis can have on a baby worried him. Clinical texts from the turn of the twentieth century advised physicians to treat pregnant patients aggressively to avoid infecting the embryo. A medical text on syphilis from 1908 warned: "Syphilis has a most pernicious effect on pregnancy. It has long been recognized that it is a fertile cause of abortion and premature delivery."<sup>2</sup> Cook thought Lulyatumanyi's case demanded urgent treatment. He prescribed weekly intramuscular injections of Grey Oil, a mercuric compound

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<sup>1</sup> "Mrs. A.R. Cook Dispensing Medicine on Safari," in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 146.

<sup>2</sup> William J. Gow, "Syphilis in Obstetrics," in *A System of Syphilis* ed. D'Arcy Power and J. Keogh Murphy (London: Oxford University Press, 1908), 359-60.

used to treat secondary syphilis.<sup>3</sup> In addition to treating Lulyatumanyi's syphilis aggressively, such injections also gave Cook direct control over the therapy, so that he did not have to rely on Lulyatumanyi (or her kin) to manage her treatment.<sup>4</sup>

However, intramuscular mercury injections were excruciating, and created a significant risk of acute mercury poisoning. Mengo's subaltern African staff, young and predominantly Baganda, may have administered her injections. To prevent soreness of the mouth and other classic symptoms of mercury poisoning, Cook prescribed *lotio alum*, an abrasive mouthwash, to remove plaque build-up. Despite this measure, Lulyatumanyi's mouth became sore shortly after treatment started. Rather than continue treatment, Lulyatumanyi ran away from Mengo Hospital after two weeks and two intramuscular injections. Her case notes indicate, without proving, that it was the rigors of the treatment itself that led Lulyatumanyi to run away.<sup>5</sup>

How Cook and Lulyatumanyi, respectively, likely interpreted these events suggests the paradox at the heart of anti-venereal treatment at Mengo Hospital. Cook thought he was saving an innocent child through effective treatment. Lulyatumanyi's interpretation is more difficult to judge, though running away certainly hints that she saw her treatment as a violent physical and symbolic act. In the previous chapter I examined how the Cooks designed and shaped Mengo Hospital to fit their evangelical and moralizing objectives. This chapter demonstrates that the actual practice of treatment at Mengo was a matter of negotiation between European medical practitioner and African patient, rather than sheer imposition.

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<sup>3</sup> D'Arcy Power, "Treatment by Intramuscular Injection of Mercury and of Arsenic," in *A System of Syphilis* ed. D'Arcy Power and J. Keogh Murphy (London: Oxford University Press, 1908), 220-241.

<sup>4</sup> Sir W. Watson Chenye and F. F. Burghard, *A Manual of Surgical Treatment* (London: Longmans, Green and Co., 1912), 222-3.

<sup>5</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, Albert Cook Memorial Library, 2194. Zulula Lulyatumanyi admitted December 26, 1921.

In the context of treatment negotiation, the distinction between meaning and form comes to the fore. This chapter builds on the arguments of Nancy Rose Hunt, Jean and John Comaroff, Annemarie Mol, and, in particular, Luise White. All of these scholars of medical practice point to the intellectual gap between the physical form of an object and the symbolic power ascribed it.<sup>6</sup> Still, as the previous chapter showed, to use Rita Headrick's words: "The conquerors aimed to remake Africans in their own image."<sup>7</sup>

The negotiation of medical treatment began with the overtures of medical missionary or state doctors to African patients. They worked to convince patients of the necessity of care and to persuade them to accept the treatment they offered. Negotiations then continued during treatment on physical, as well as epistemic, levels. Although European nurses and doctors prescribed and administered medications, trained Baganda subalterns also administered these treatments, and kin and traditional healers also affected care. Through these negotiations, the Baganda made their own evaluations of the success and meanings of biomedicine, and thus defined the terms on which biomedicine would be assimilated into Ganda life.

### **Conversations**

Neither the missionaries at Mengo Hospital, nor colonial doctors at the state-run Mulago Hospital could simply rely on the Baganda to submit themselves or their kin to treatment. They had to convince and persuade patients and their relatives to allow patients to

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<sup>6</sup> Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, NC: Duke University Press, 1999); Jean and John L. Comaroff, "The colonization of consciousness in South Africa," *Economy and Society* 18, no. 3 (August, 1989); Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Durham and London: Duke University Press, 2002); <sup>6</sup> Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley, Los Angeles, and London: University of California Press, 2000), 89-121; Luise White, "'They Could Make Their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda," *The American Historical Review* 100, no. 5 (December, 1995): 1379-1402.

<sup>7</sup> Rita Headrick, *Colonialism, Health, and Illness in French Equatorial Africa 1885-1935* (Atlanta: African Studies Association Press, 1994), 1.



attend anti-venereal clinics. Thus, both missionary and state doctors engaged in processes of wooing. But colonial officials could also rely on the coercive power of the state, while missionaries had to rely on persuasion alone to convince the Baganda to accept missionary medical care. Ironically, successfully convincing patients to accept biomedical care required medical missionaries to adopt Ganda modes of expression. Once in the clinic, missionaries and colonial officials had to continue to entice and reassure patients and their kin. I argue that these conversations of persuasion, far from being encounters in which colonial authorities simply imposed their ideas about disease, afforded the Baganda a medium to assert their conceptions of venereal disease, and to participate in a biomedical dialogue.

From the very onset of the syphilis “outbreak,” medical missionaries produced propaganda warning the Baganda of the dangers that syphilis posed to individuals and to the Kingdom of Buganda. In 1908, Cook’s brother Jack wrote a pamphlet in Luganda on the connection of syphilis to infant mortality entitled: “*Okufa Okwabana Mu Buganda Bwekuli* [What is the prevalence of infant mortality among the Baganda?]. With the help of the government printer, 5,000 copies were produced and distributed: 2,000 copies to the CMS, 1,000 to the Mill Hill Mission, 1,000 to the White Fathers Mission, and 1,000 to colonial medical officers and regional chiefs (*saza*).<sup>8</sup> In his pamphlet, Jack Cook cast the fight against syphilis as a matter of national pride. He asked his readers:

*Naye abana bwebafa bwebatyo mu Buganda amanyi nobugaga nekitibwa ebya Baganda mu biro ebigenda okuja biryenkana wa?*

If so many children die in the Kingdom of Buganda, what will be the source of Buganda’s future pride and wealth?<sup>9</sup>

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<sup>8</sup> George Wilson to CMS, June 19, 1908 Incoming Correspondence 1899; 1900-1914, ACML.

<sup>9</sup> J.H. Cook *Okufa Okwabana Mu Buganda Bwekuli* trans. Robinson Kisaka (1908), ACML.

After contending that the fate of the Kingdom of Buganda was at stake, Cook blamed the epidemic on “native” backwardness and ignorance. He attributed the alarming rate of infant mortality to:

*(1)Endwade ezobukaba mu bakade babwe. (2) Obutamanya obwa banyabwe nobwa bakitabwe; kubanga tebamanyi kujanjaba abana babwe, nempisa zabwe ezomukisera ekyokuzala za butamanya bwerere.*

[(1) venereal diseases passed along from the parents. (2) mothers’ and fathers’ ignorance about how to raise their children.]<sup>10</sup>

While deprecating Baganda parenting skills and hygiene, Jack Cook also denigrated traditional Ganda healing practices, blaming them for maternal deaths. He wrote:

*Temuganyanga banabwe nakatono kubasiga omubiri nedagala eryekiganda, newakubade nga balwoza okutubera. Edagala eryo liinza okubalwaza*

[Do not allow your husband or kin to smear you with Ganda drugs. Those drugs can cause serious problems and even death.]<sup>11</sup>

In opposition to the dangerous, potentially fatal, local medicine, Jack Cook asserted that white hospitals saved lives, and he therefore implored his readers to take pregnant women to these clinics instead:

*Era nabakazi abazala bafa bulijo; songa bandiwonye singa omusawo omuzungu yababera. Kyekiva kibasanira okuingira mu Dwaliro lya Abazungu bwekiinzika, omusawo abazalise.*

[Pregnant mothers die every day, though they would survive if they came to the white doctor. That is why it is important to always come to a white doctor to ensure a good delivery.]<sup>12</sup>

Jack Cook’s pitch to the Baganda was that infant mortality due to “native” incompetence in raising children, and Ganda medicine threatened the Kingdom’s prominence, so that the Baganda should rely on European doctors and medicine to protect them. What is most

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<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

intriguing about this pamphlet is its intended audience: the Baganda. The pamphlet was designed to convince the Baganda to attend European clinics. It also in effect invited the Baganda into participating in a discourse about venereal disease. Though direct Baganda responses to Jack Cook's pamphlet have not been found, subsequent missionary and colonial propaganda campaigns met with a mixture of resistance and support.

Albert Cook's "Social Purity Campaign," initiated as a joint government-missionary anti-venereal propaganda effort in 1921, further drew the Baganda into a dialogue about syphilis, the epidemic, and European treatments. Albert Cook stressed many of the same points that his brother Jack had: "[I]n five successive years the number of deaths [have] surpassed the number of births by 64,000 and ... by continuance of this process [the] nation [Buganda] would ultimately become extinct."<sup>13</sup> However, Albert Cook also emphasized the "underlying moral causes of the epidemic."<sup>14</sup> At Ndeje, for example, he began a lecture by quoting Proverbs 6:20-35, which warns against sexual immorality and adultery: "Whoso committeth adultery with a woman lacketh understanding: he that doeth it destroyeth his own soul. A wound and dishonour shall he get; and his reproach shall not be wiped away."<sup>15</sup> In Kikoma, Cook similarly stressed the ties between syphilis and immorality, emphasizing the importance of marriage within the church and teaching children good manners, and the dangers of drink.<sup>16</sup> In his "Social Purity Campaign," therefore, Cook tried to persuade his audience that failure to live by British social mores—monogamous church-sanctioned marriages and steering clear of alcohol—had caused an epidemic that threatened the very

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<sup>13</sup> A.R. Cook, "A Social Purity Campaign," *Mercy and Truth* 25 (1921): 299.

<sup>14</sup> *Ibid*

<sup>15</sup> A.R. Cook, "A Social Purity Campaign," *Mercy and Truth* 25 (1921): 272; Prov. 6:32-33 (King James Version).

<sup>16</sup> A.M.B.K. "Okubulira Okukulu Okwa Dr. A.R. Cook. C.M.S. Kikoma Buwekula," *Ebifa mu Buganda* trans. Roinson Kisaka (April, 1921).

existence of the Buganda Kingdom, a “nation” inside the Uganda Protectorate, that was administered through indirect rule.

According to Cook, least some Baganda, it seems, were convinced that adopting new morals would solve the syphilis epidemic. Cook related that some of his audience shared his views, and condemned “native customs and dances, which led directly to immorality...the evil influence of drink.” These same persons, he said, understood the critical importance of taking “Christ as their personal Savior and Friend.”<sup>17</sup> Since Cook’s own biases color his report, such alleged responses might well be taken with a grain of salt.

Other audiences offered different views about the epidemic. Some believed that reinforcing traditional Ganda mores would remedy the situation. Some argued: “Young girls, too, are allowed far too much freedom in visiting their friends unaccompanied by an older woman.”<sup>18</sup> Thus, to these members of Cook’s audience, going back to the old Ganda ways, with increased oversight from the older generation, rather than adopting European mores, would stem the proliferation of immorality.

Still others identified structural and economic factors that had caused venereal disease to spread. Some argued that the “want of privacy in the home” undercut parental moral authority.<sup>19</sup> Poverty and cramped living conditions, they asserted, prevented the creation of a more virtuous society, free from venereal disease. These observations gave voice to anti-colonial sentiments: the Buganda Agreement of 1900 and the imposition of hut taxes had significantly impoverished Baganda peasants (*bakopi*).<sup>20</sup> Cook’s audience likewise observed that economic impediments to marriage resulted in extramarital sex: “It was pointed out that

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<sup>17</sup> A.R. Cook, “A Social Purity Campaign,” *Mercy and Truth* 25 (1921): 299.

<sup>18</sup> *Ibid.*

<sup>19</sup> *Ibid.*

<sup>20</sup> Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 199, 204.

the almost universal demand for high dowries by greed-loving parents from would-be suitors for their daughters' hands seriously discouraged marriage, and led to irregular unions."<sup>21</sup> The sum paid to brides' families, or bridewealth, rose astronomically after the imposition of colonial rule: by 1896, two years after Uganda became a Protectorate, the cost of marriage rose from 2,500 to 10,000 cowry shells, and in 1901, the Baganda parliament (*lukiiko*), alarmed that marriage was becoming increasingly unaffordable, capped bridewealth for *bakopi* at 10,000 cowries. Ironically, it was largely colonial and missionary anti-polygamy efforts that caused this exponential rise in bridewealth, ultimately making marriage unaffordable and perhaps contributing to the spread of venereal disease.<sup>22</sup>

Some of Cook's audience also simply resisted his message. Cook repeated that at the end of his lecture, a *bamalaki* heckler "interrupted by saying that as these diseases came from God, what was the use of trying to cure them?"<sup>23</sup> Katherine Cook, delivering a similar lecture for women, also met with resistance. Albert Cook wrote that *bamalaki* "were much more in evidence, and something like organized opposition was shown."<sup>24</sup> These displays of dissent and divergence illustrate that colonial propaganda, rather than establishing a monolithic understanding of the syphilis epidemic, instead opened up space for dialogue, new interpretations, and outright refusal of the "message."

### **Dialogues in the Clinic**

Inside Mengo Hospital, dialogues and negotiations over the meaning of treatment continued. In his memoir, Cook reported on a fairly typical conversation with a patient:

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<sup>21</sup> A.R. Cook, "A Social Purity Campaign," *Mercy and Truth* 25 (1921): 299.

<sup>22</sup> Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 139-40. A similar phenomena has been observed in the spread of HIV/AIDS among migrant mining laborers in South Africa, Zimbabwe, and Zambia. Mark Hunter, "Cultural Politics and Masculinities: Multiple-partners in Historical Perspective in KwaZulu-Natal," *Culture, Health & Sexuality* 7 (2005): 209-23;

<sup>23</sup> A.R. Cook, "A Social Purity Campaign," *Mercy and Truth* 25 (1921): 299-300.

<sup>24</sup> *Ibid.*, 300.

*Doctor:* What is the matter with you?

*Patient:* My name is so and so.

*Doctor:* Yes, but where is your disease?

*Patient:* I want medicine to drink.

*Doctor:* Where are you hurt?

*Patient:* I don't want medicine to swallow, but to drink.

*Doctor (sternly):* WHERE IS YOUR ILLNESS?

*Patient:* Oh, it goes all over me; it cries out "Ka ka". Will you listen to the top of my head with your hearing machine? (stethoscope) etc., etc.<sup>25</sup>

This dialogue clearly illustrates that even when seeking biomedical care, Baganda patients did not simply take up biomedical practices, but rather negotiated them. Cook observed a similar popularization of biomedical forms, without understanding or acceptance of biomedical ideologies, during his tours around the country. He recounted:

No sooner did the news go round that the *Musawo* (doctor) had arrived than a crowd of from one to four hundred quickly collected. Many of course were merely drawn by curiosity, and had nothing the matter with them...[we] let them have a good sniff at a solution of strong liquor ammoniacae. With tears streaming down their faces, but with grateful hearts, they retired to make room for others.<sup>26</sup>

The crowd, though eager to experience biomedicine, clearly understood it within the framework of an African system of healing—as a charm—rather than from a biomedical curative perspective. Moreover, as discussed in Chapter Two, even when patients attended Mengo Hospital, their kin often mixed their own brand of care with biomedical treatments.

The Luganda-English medical phrasebook that Albert Cook originally published in 1903 provides insight into the strategies Cook used to try to control his encounter with patients. To analyze this phrasebook, I draw on Keletso Aktin's analysis of Zulu-English phrasebooks—"snippets of 'dialogue' frozen in time between masters and their servants"—to

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<sup>25</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 123. I am indebted to Luise White's work on Uganda for this reference.

<sup>26</sup> *Ibid.*, 93.

recover an African voice.<sup>27</sup> To try to recover the voices of Mengo’s patients, I focus on the phrases and translations Cook provided for the “Medical Interrogation,”<sup>28</sup> including queries about symptoms and treatment, warnings, requests, instructions, orders, and even threats, to secure cooperation. Together these phrases comprise an arsenal of strategies directed at convincing patients and their kin to comply with treatment, and thereby provide insight into the therapeutic conversations between doctor and patient. The phrases can be divided into two broad categories: those designed to shape a patient’s evaluation, interpretation, and understanding of pain in treatment, and those eliciting patient compliance with the treatment regimen.

Thus, Cook provided phrases to help medical staff manage patient responses to pain, indeed ultimately to mold patients’ understanding of their pain. These phrases highlight that physical pain, sometimes unavoidable in biomedical practice—especially in treatment with toxic substances such as mercury—discouraged and threatened patients. Cook instructed his fellow doctors to tell Muganda patients: “Be brave; you will not be hurt much . . . *Guma; toja kulumwa nyo.*”<sup>29</sup> This phrase shifts the focus away from the potential pain of a procedure and toward the patient’s character, courage, and ability to endure physical discomfort. The recommended phrase underlines that to induce patients to endure the painful procedures he purveyed, Cook framed them as an opportunity to demonstrate bravery and strength.

Other recommended phrases are dual-purpose: aimed at convincing patients to submit to biomedical treatment, while also avoiding responsibility for any failure of treatment. Thus he recommended the phrase: “It will be your fault if the man dies . . . *Omusango gwo*

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<sup>27</sup> Kelesto E. Aktins, *The Moon is Dead! Give Us Our Money!: The Cultural Origins of an African Work Ethic, Natal, South Africa, 1843-1900* (Portsmouth, NH: Heinemann, 1993), 5.

<sup>28</sup> A.R. Cook, *A medical vocabulary and phrase book in Luganda* (Kampala, Uganda & London: Uganda Book Shop & Society for Promoting Christian Values, 1921) 8-11.

<sup>29</sup> *Ibid.*, 9.

*omulwade bwanafa.*” This phrase, directed at kin and followers who accompanied a patient, or perhaps to “traditional” healers, highlights the ambivalence of Baganda patients and kin toward Western biomedicine, suggesting both that the Baganda could only be convinced to try the white doctors’ cures when looking death in the face, and that, when they did turn to Mengo, they demanded extraordinary results, and blamed failure on the doctors. Another phrase: “Do you wish to die? ... *Wegomba kufa?*” was similarly ambivalent—even schizophrenic—in enlisting the ultimate consequence – death – to get patients to submit to treatment, while also trying not to promise too much. It mirrors, in its ambivalence, the attitudes of the patients to whom it was directed.

The phrasebook also provides a number of less coercive phrases to ensure patient collaboration. These ultimately reveal the difficulty doctors and nurses had in establishing and maintaining control over the medical encounter. Cook provided translations for phrases like: “Let me see your tongue ... *Leta olulimi, ndabe.* Open your mouth ... *Yasama akamwa.* [...] Let your body go loose ... *Jenjeka omubiri gwo.* [...] Undress ... *Yambula.*”<sup>30</sup> Obviously, these phrases were designed to make medical practice easier. That such phrases were needed to mediate the examination underlines how new and different the forms of biomedicine were for Mengo’s patients. These phrases also emphasize the “bottom line” that doctors encountered in the clinic: success in treating patients depended on the cooperation of patients and kin. That cooperation entailed a dialogue between doctor and patient in which the forms and meaning of treatment were negotiated, changed, and ultimately assimilated as a new “hegemony,” as defined by the Comaroffs.

Treatment also required patients to follow instructions after leaving the clinic. Cook translated several phrases for asking patients to return: “Come every day for medicine . . .

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<sup>30</sup> Ibid., 8-10.



*Onojanga bulijo owebwedagala. Come tomorrow morning ... Oja enkya. Come back in two days' time ... Ojanga olwebiri. Come every other day ... Oyasangayo lumu noja.*<sup>31</sup> These phrases also made clear that biomedical treatment required patients to invest and organize their time around a doctor's demands; again a negotiation of treatment, that could change its meaning, was required.

The negotiation of treatment was not always successful: not all patients found such demands reasonable, and clinical records reveal that patients and their kin at Mengo Hospital often resisted treatment to greater or lesser degrees. Dr. Keane wrote Cook of a patient exhibiting "passionate resistance," an "objection to medicine of any kind." He added: "Doubtless you have often met such Baganda."<sup>32</sup> Some patients ultimately refused treatment altogether, and ran away. Consider the following selection of cases, one from 1915 and three from 1921:

Table 4: "Runaway" patients from Mengo Hospital<sup>33</sup>

Patient Name	Date Admitted	Duration of Stay	Religion	Reason for Visit	"Disease"	"Result"
Yokana Muwereza	May 4, 1915	5 days	Baptized Protestant	General rash	"Syphilis"	"Ran away-Improved"
Eseza Nsungi	May 7, 1915	3 days	N/A	Noticed that baby had a "general eruption" on head	"Congenital Syphilis"	"Ran away-Unimproved"
Musa Wakisimbi	November 14, 1921	2 days	N/A	N/A	N/A	"Ran away"
Mulisi Lereauga	November 21, 1921	52 days	Roman Catholic	Soft sores on penis	"Syphilis"	"Ran away-Improved"

<sup>31</sup> Ibid., 8-9.

<sup>32</sup> G.J. Keane to A.R. Cook, March 27, 1914, Incoming Correspondence 1913-1914, letter Box 4. ACML.

<sup>33</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 910. Yokana Muwereza admitted May 4, 1915; Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 925. Eseza Nsungi admitted May 7, 1915; Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, 1956. Musa Wakisimbi admitted November 14, 1921; Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, Mulisi Lereauga admitted November 21, 1921.

Zulula Lulyatumanyi	December 26, 1921	16 days	Roman Catholic	Sores on vulva and general rash appearing 3 weeks ago	"Syphilis"	"Ran away- Unimproved"
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These patients' actions suggest refusal, frustration, and disobedience: in short the breakdown of the negotiation of treatment between the biomedical practitioners and their Baganda patients. Regardless of the individual reasons for that breakdown, these cases make clear that the process by which the ideology and appurtenant hegemony that Mengo Hospital sought to advance were assimilated by the Baganda was a matter of fits and starts. Though many syphilis patients refused and ran away from treatment, hundreds of Baganda sought biomedical care from the CMS by the close of the 1920s. Cook reported that: "Between five and six hundred confinements [pregnancies] are treated at the Lady Corydon MTS annually."<sup>34</sup> Thus, while the clinical and evangelical medical mission produced grateful patients and hopeful converts, it also produced fear, resentment, defiance, and refusal.

### **Mercury, Arsenic, and Circumcision**

The runaway case notes do not include tidy explanations of why some patients chose to leave Mengo Hospital rather than continue treatment. Examination of the treatments associated with syphilis at Mengo, however, may provide some clues. Careful examination of treatments also illuminates fundamental contradictions and difficulties associated with combining medical practice and evangelization, leading to an ambivalence on the part of the missionary doctors toward available syphilis treatments that mirrors that of patients.

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<sup>34</sup> A.R. Cook, *The Treatment of Ante-Natal Syphilis in Buganda Women*, delivered to the UBBMA on March 22, 1929.

Case sheets report that syphilis patients were treated with “Mist. Hydr.,” mercury formulations, or “606,” Salvarsan, an arsenic based formulation, and by circumcision.<sup>35</sup> We need to consider what these treatments were, how they felt, and what clinical effect they were understood to have at the time. Moreover, what was the significance of these treatments for Mengo’s medical missionaries? And, finally, how may Baganda reactions to them have differed? The missionaries hoped that their medical treatments would produce grateful patients open to the possibility of conversion. However, the economic realities of running a hospital, as well as the evangelizing mission, affected how the missionaries carried out their syphilis treatment. Patients, meanwhile, evaluated treatments based on their own curative concepts, often undermining evangelical efforts in surprising ways. We now turn to Mengo Hospital’s use of mercury, arsenic, and circumcision in syphilis treatment, and patients’ perception of the same.

### **Mercury**

Mercury, abbreviated in the Mengo Hospital case notes as Hg, Hyd., Hydrarg., etc., or *hydrargrum*, was the basis and workhorse of syphilis treatment at Mengo Hospital until at least 1927, as the hospital continued to rely on this treatment even after arsenic-based treatments had replaced mercury as the state-of-the-art treatment for syphilis in Europe. This continued use of mercury reflected both economic factors—cost and availability— and the evangelizing views of the missionaries.<sup>36</sup>

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<sup>35</sup> Although not discussed in this paper, potassium iodide was also prescribed along with mercury to treat secondary syphilis. Additionally, in the late 1930s bismuth injections started being used incongunction with arsenic. Penicillen eventually became the standard treatment for syphilis.

<sup>36</sup> Mengo Hospital In-Patient case notes, 1927, Mengo Hospital Papers, ACML, 1445 Lalaska Bangiasbero admitted November 21, 1927; M. W. Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 223.

In 1908, Col. Lambkin stated: “[A]fter having been employed in the treatment of syphilis for at least four hundred years, and having passed through the furnace of fierce and heated discussions, mercury is now firmly established in the estimation of all syphilologists as the true specific and antidote for syphilis.”<sup>37</sup> During those four hundred years of experimentation, Europeans had developed a wide array of modes of mercury administration, of varying toxicity and pain, though all mercury treatments for syphilis had one thing in common: they required extended periods of treatment.

In 1929, long after mercury treatment had ceased to be fashionable in Europe, Cook still recommended “a mixture containing one forty-eighth part of a grain of Hydrag. Perchlor. [Hg(ClO<sub>4</sub>)<sub>2</sub>, Mercury Perchlorate] to the ounce of water, coloured bright blue by Methylene blue & taken thrice daily.”<sup>38</sup> Cook provided this remedy to pregnant mothers in his clinic for only 10 cents per week, or a total of 3 shillings and 7 pence over the pregnancy.<sup>39</sup> Such oral mercury treatments were relatively painless, at least at the time of administration. But the amount of mercury absorbed was variable, and the course of treatment the Royal Army Medical Corps (RAMC) recommended lasted almost two years.<sup>40</sup>

Cook also prescribed mercury administered through ointments, by the rubbing of “*uguentum hydradyri*” into the skin, often in the groin, for secondary syphilis cases requiring “urgent” treatment.<sup>41</sup> Again, the RAMC-recommended course of syphilis treatment with mercurial ointment involved five courses of treatment, again lasting in total just under two

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<sup>37</sup> F.J. Lambkin, “Mercury,” in *A System of Syphilis Vol. II* ed. D’Arcy Power and J. Keogh Murphy (London: Oxford University Press, 1908), 260.

<sup>38</sup> A.R. Cook, *The Treatment of Ante-Natal Syphilis in Buganda Women*, delivered to the UBBMA on March 22, 1929.

<sup>39</sup> *Ibid.*

<sup>40</sup> W.W. Cheyne and F.F. Burghard, *A Manual of Surgical Treatment Vol. I* (London: Longmans, Green and Co., 1912), 218-20.

<sup>41</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 880 Mohomat Rahan admitted April 30, 1915; W.W. Cheyne and F.F. Burghard, *A Manual of Surgical Treatment Vol. I* (London: Longmans, Green and Co., 1912), 220-1.

years.<sup>42</sup> As illustrated by Sibayalika's case, mercury ointments could ravage already irritated tissues. Lambkin opined that while mercury ointments had a more dramatic therapeutic effect than oral preparations, in view of the irritation and eruption of pustules they could produce, they could only be used intermittently.<sup>43</sup>

Intramuscular mercury injection was the most common syphilis treatment at Mengo Hospital through the 1920s. Like the other mercury treatments it also took a long time: five courses of treatment, with four to six injections per course, over two years.<sup>44</sup> It was also excruciating.<sup>45</sup> In 1908 D'Arcy Power, who co-authored and edited the six volume, *A System of Syphilis*, wrote:

The pain causes functional disturbances, which vary according to its severity. The patient may be entirely confined to his bed; he may have difficulty in sitting up, or in lying upon the painful spot; he may limp or may complain of difficulty in going up and down stairs. The acute pain seldom lasts more than two to four days, but aching and difficulty in walking may last several days longer.<sup>46</sup>

Nevertheless Lambkin, who developed his own method of intramuscular treatment, claimed injection offered significant advantages over ingestion and ointment because dosages were more certain, and, equally important, doctors had more direct control over treatment.<sup>47</sup>

Lambkin's logic made intramuscular injections popular for public health services, especially in cases where physicians doubted a patient's willingness or ability to administer

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<sup>42</sup> W.W. Cheyne and F.F. Burghard, *A Manual of Surgical Treatment Vol. I* (London: Longmans, Green and Co., 1912), 221.

<sup>43</sup> F.J. Lambkin, "Mercury," in *A System of Syphilis Vol. II* ed. D'Arcy Power and J. Keogh Murphy (London: Oxford University Press, 1908), 278; W.W. Cheyne and F.F. Burghard, *A Manual of Surgical Treatment Vol. I* (London: Longmans, Green and Co., 1912), 221.

<sup>44</sup> W.W. Cheyne and F.F. Burghard, *A Manual of Surgical Treatment Vol. I* (London: Longmans, Green and Co., 1912), 223.

<sup>45</sup> W.W. Cheyne and F.F. Burghard, *A Manual of Surgical Treatment Vol. I* (London: Longmans, Green and Co., 1912), 223.

<sup>46</sup> D'Arcy Power, "Treatment by Intramuscular Injection of Mercury, and the Organic Compounds of Arsenic," in *A System of Syphilis Vol. II* ed. D'Arcy Power and J. Keogh Murphy (London: Oxford University Press, 1908), 230.

<sup>47</sup> *Ibid.*, 281-4.

treatment.<sup>48</sup> Under Lambkin's instruction, the Protectorate government based its initial anti-venereal campaign on mass intramuscular injections of mercury.<sup>49</sup> A colonial official, James Will, confessed in a 1908 letter to Cook that the pain from injections was turning patients away: they refused to return for additional shots.<sup>50</sup> According to Kalibala, reactions to these invasive biomedical treatments generated considerable fear, and rumors circulated through villages:

The treatment at the clinic was not what the people expected....it was known as a *ekato*, or a giant needle....Tale after tale spread all over the towns and villages that the white man was using a giant needle which he pushed inside the male organs after which a man was sexually incapacitated.<sup>51</sup>

Though Kalibala does not specify what treatment generated the myth of *ekato*, the procedure sounds similar to that for gonorrhea, which involved daily irrigation of the urinary tract with an antiseptic. Regardless, it is clear that mercury injections were regarded with similar anxiety and suspicion.

Beyond the pain of administration, mercury treatment for syphilis could result in serious complications, as also evidenced by Sibyalika's case note. Albert Cook's brother, Jack Cook, who was also a medical doctor involved in treatment of venereal disease in the early years of the syphilis epidemic, thought the Baganda were particularly susceptible to the complications of mercury treatment. Lambkin once reported that Jack Cook "never gave more than gr. 1/12 of metallic mercury to any natives, for fear of trouble. He [Jack] instanced many cases which had become severely salivated after what, elsewhere, would

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<sup>48</sup> W.W. Cheyne and F.F. Burghard, *A Manual of Surgical Treatment Vol. I* (London: Longmans, Green and Co., 1912), 218-19.

<sup>49</sup> Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925." *Signs* 16, no. 4 (Summer, 1991): 791.

<sup>50</sup> J. Will to A.R. Cook, September 25, 1908, ACML. I am indebted to Carol Summers for this reference.

<sup>51</sup> Ernest Balintuma Kalibala, "The Social Structure of the Baganda Tribe of East Africa" (PhD diss., Harvard University, 1946), 512. I am indebted to Tuck for this reference.

have been considered absurdly small doses.”<sup>52</sup> Albert Cook likewise wrote that the Baganda had an “extraordinary idiosyncrasy” with mercury treatments that caused “not a few deaths [following] the intramuscular injection of Lambkin’s grey-oil [mercury compound] till this basic fact had been grasped.”<sup>53</sup>

The “salivation” referred to by Lambkin, also called “mercurialism,” signaled serious mercury poisoning, and presaged more severe symptoms.<sup>54</sup> Patients would first produce copious amounts of saliva; if treatment continued, more ominous symptoms would appear: ulceration of the gums, anemia, bloody diarrhea, loose teeth, rashes, pain in the extremities, paranoia, and death.<sup>55</sup> Accordingly, at Mengo Hospital doctors took precautions to prevent salivation, prescribing an astringent mouthwash of *lotio alum* thought to reduce the risk of salivation, though these measures often proved ineffective.<sup>56</sup>

To missionaries and colonial officials, the Baganda’s acute response to mercury treatment seemed an interesting illustration of racial difference. For Baganda patients, however, treatment-related complications and deaths likely reinforced negative perceptions of Mengo and biomedicine, and inhibited recourse to the hospital for treatment. Rumors circulated throughout Eastern African about *bazimamoto* or “vampires,” usually white men or black men working for white men, who captured Africans and, using tools that could be

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<sup>52</sup> F.J. Lambkin, “Mercury,” in *A System of Syphilis Vol. II* ed. D’Arcy Power and J. Keogh Murphy (London: Oxford University Press, 1908), 283.

<sup>53</sup> A.R. Cook “The Treatment of Ante-Natal Syphilis in Buganda Women” (March 22, 1929): 2; Also see A.R. Cook, *A medical vocabulary and phrase book in Luganda* (Kampala, Uganda & London: Uganda Book Shop & Society for Promoting Christian Values, 1921) 45.

<sup>54</sup> A.R. Cook “The Treatment of Ante-Natal Syphilis in Buganda Women” (March 22, 1929): 8-11.

<sup>54</sup> D’Arcy Power, “Treatment of Syphilis,” in *A System of Syphilis Vol. II* ed. D’Arcy Power and J. Keogh Murphy (London: Oxford University Press, 1908), 195.

<sup>55</sup> *Ibid.*, 195-6.

<sup>56</sup> J.N. Neligan and D. M. Reese, *Medicines, their Uses and Mode of Administration* (New York: Harper & Brothers, 1844), 60.; Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 880 Sibyalika admitted May 9, 1915.

found in Mengo, drained their blood to produce medicines for white children.<sup>57</sup> Additionally, stories of European cannibalism fired the imaginations of Mengo Hospital's patients. In 1899, Katherine Timpson wrote that mothers told their children stories about cannibalistic white doctors "as a means of keeping them quiet..."<sup>58</sup> Serious injury and deaths from mercury treatment resonated with these stories of white hospitals and doctors as places and persons of nefarious activity.

To compound the problem, mercury treatment was not always effective. Mulisi Lereauga, for example, who went to Mengo after noticing sores on his penis and the underside of his scrotum, was prescribed a mercurial ointment to be rubbed on his groin every Saturday. Lereauga stayed at Mengo for 51 days, from November 21, 1921 to January 11, 1922; however, when he left, all the case notes could say was that his condition was "improved."<sup>59</sup>

Altogether, the long time that it took for mercury to effect a cure, the pain of intramuscular administration, the medical complications, and the possibility of death, all made mercury a problematic therapeutic option. Ironically, however, as discussed below, the attributes of mercury treatment that alienated Baganda patients, were, to some degree, its evangelical advantages. But these were only advantages if patients would submit to treatment. As the incidence of run-aways makes clear, Baganda patients could and did participate in and influence the dialogue of treatment, sometimes "voting with their feet" to reject Cook's medicine.

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<sup>57</sup> Luise White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley and Los Angeles: University of California Press, 2000).

<sup>58</sup> Katherine Timpson, "Patients and Nurse at Mengo," *Mercy and Truth*, 3 (December, 1899): 290; Luise White, "'They Could Make Their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda," *The American Historical Review* 100 no. 5 (December, 1995): 1388.

<sup>59</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, Mulisi Lereauga admitted November 21, 1921.



## Arsenic

While mercury, though inexpensive, was only marginally effective, was painful and arduous in administration at best, and was very dangerous, arsenical treatments were thought to be effective and safe for the treatment of syphilis. In 1910, Paul Ehrlich invented one of the first arsenical treatments specifically designed to target syphilis, and called it Salvarsan, or “606.” Salvarsan’s effects were dramatic and quick: “Its effects,” Cook wrote, “on the worst cases are simply magical.”<sup>60</sup> Cook claimed to have seen full blown cases of syphilis, “repulsive wretches” covered in crusty sores, cured 10 days after a single dose.<sup>61</sup> In 1933 he told CMS members that syphilis was cured with 606 “daily.”<sup>62</sup> Though it was more expensive and the recommended course of treatment was actually longer than that for mercury, its effects were so dramatic that Salvarsan treatments became very popular.<sup>63</sup>

As a result, Salvarsan treatment was an economic boon to Mengo, where patients were required to pay for treatment, because patients were eager to pay for it. All this begs the question: Why did Mengo persist in relying on mercury treatment for so long after 606 became available? My review suggests that the Mengo doctors perceived that administering a “quick,” effective, and relatively painless treatment for syphilis would undermine their evangelical mission. In this connection, the long course of treatment required for mercury treatment provided time to evangelize a captive audience. And, as discussed above, the Mengo doctors sought to take advantage of patients’ vulnerability to convert them; that vulnerability was enhanced as patients experienced the rigors of mercury treatment. Finally, Mengo’s hesitation in adopting arsenical treatment may reflect concerns voiced in the CMS

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<sup>60</sup> Ibid., 51.

<sup>61</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 52.

<sup>62</sup> A.R. Cook, “Report of the CMS Mengo Hospital Mission.” (1933).

<sup>63</sup> M. W. Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 216.

when Cook was first establishing the clinic that Cook's medical work could attract patients who would accept the material benefits, but pass up the morals.<sup>64</sup> Thus, Jack Cook, considering the colonial administration's scheme to address syphilis solely with medication, remarked: "I cannot help feeling that this... is yet tackling the problem from the wrong end. I believe that it would be more scientific to tackle the cause, the moral cause, rather than the physical result."<sup>65</sup> Possibly the "easy" cure arsenic injection provided, obviating the need for moral reform, may have led missionaries to prefer mercury treatment to "606."

The Baganda, meanwhile, understood Salvarsan differently from Mengo's doctors, and arsenical injections were immensely popular amongst the Baganda and brought new patients, and possible converts, to Mengo. Many Ugandans were disappointed when the government hospital, Mulago, was out of Salvarsan from April until August of 1921. In December that year, some patients made appointments at Mengo Hospital expressly to receive Salvarsan injections.<sup>66</sup> Dr. Webb, however, wrote that "natives" harbored the impression that "one dose of 606 constitutes full insurance against the continuance of the disease and renders further treatment unnecessary."<sup>67</sup> Dr. Leakey, a CMS doctor in Toro, in western Uganda, wrote that his patients thought "606" injections were magical, like a "fetish."<sup>68</sup> And Cook experienced instances in which well persons insisted on getting "606" injections. Samioni Kiimba made an appointment in 1921 specifically to receive a 606 shot.

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<sup>64</sup> W.D. Foster, "Dr Albert Cook and the Early Days of the Church Missionary Society's Medical Mission to Uganda," *Med. Hist* 12, no. 4 (October, 1968): 330.

<sup>65</sup> Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925." *Signs* 16, no. 4 (Summer, 1991): 797.

<sup>66</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, 2201 Samioni Kiimba admitted December 27, 1921; G.J. Keane, "Annual Report on Venereal Disease Measures, Uganda, for 1921," in *Annual Medical and Sanitary Report for the Year Ended 31<sup>st</sup> December, 1921*, ed. C.A. Wiggins (Entebbe: Government Printer, 1922), 66.

<sup>67</sup> W.I. Webb, "Appendix VI: Copy of letter to S.M.O., Mengo Hospital, and M.O. Nsambya," in *Annual Medical and Sanitary Report for the Year Ended 31<sup>st</sup> December, 1921*, ed. C.A. Wiggins (Entebbe: Government Printer, 1922), 78.

<sup>68</sup> Luise White, "'They Could Make Their Victims Dull': Genders Genres, Fantasies and Cures in Colonial Southern Uganda," *The American Historical Review* 100, no. 5 (December 1995): 1395.

Cook noted: “[n]o definite signs of Sy.- but has much aching of the bones and headache. Has come in expressly for 606 injection. Syphilis denied.”<sup>69</sup> Therefore, to the extent that Mengo Hospital’s doctors hoped that Salvarsan would convince the Baganda of the curative power of Western biomedicine and induce its acceptance, instead of accepting biomedicine in Western terms, some Baganda simply incorporated “606” into their own medical logic. Further, these Baganda attitudes towards “606” seemed to validate missionary concern that such treatments interfered with evangelization by reducing the opportunity to impart a European moral order that disapproved of sexual promiscuity.

Despite the reservations missionaries may have had about Salvarsan, its popularity made providing the drug a tempting source of revenue. When charitable donations fell during the First World War, Mengo Hospital fell into financial straits. In 1917, for example, Mengo ran a deficit of 14,000 Rupees, and by 1921 the deficit was as high as £42, 690.<sup>70</sup> Salvarsan gave Mengo Hospital a way out of its financial difficulties. In 1924, Jack Cook, then the Secretary of the CMS Medical Committee in London, wrote to his brother congratulating him on patient fee revenue from Neokharsivan, a Salvarsan derivative: “The profits on Neokharsivan are indeed astonishing and contribute materially to the satisfactory financial position.”<sup>71</sup> In 1925, he was even more enthusiastic about the effect of Salivarsan sales on the Mengo finances, declaring: “The figures for the Neokharsivan are very striking

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<sup>69</sup> Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, 2201. Samioni Kiimba admitted December 27, 1921.

<sup>70</sup> Stanely-Smith to Hodges, 21 May, 1917, Incoming General Correspondence 1919-1921, 1925-1930, 1917-1931, ACML; J.H. Cook to A.R. Cook May 12, 1921, Letters received by A.R. Cook from brother J.H. Cook, 1915-1916, and from brother Alfred Cook, nephew Ernest Cook, and neice Elise Cook, 1920-1921, ACML; Jan Kuhanen, *Poverty, Health, and Reproduction in Early Colonial Uganda* (Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005), 299-300.

<sup>71</sup> J.H. Cook to A.R. Cook November 13, 1924, Incoming Correspondence from CMS, 1919-32; M. W. Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 221.

and I only hope that the government will not regard it as profiteering!”<sup>72</sup> Indeed, during the interwar era, revenues from arsenical injections became an increasingly important source of revenue:

Table 5: Percentage of Mengo Hospital Revenue from Arsenical Injections, 1921-1926<sup>73</sup>

<i>Year</i>	<i>Percentage of Mengo Hospital Revenue</i>
1921	3.85%
1922	2%
1923	7.80%
1924	17.30%
1925	22.80%
1926	17.90%

Arsenical treatment, thus, proved vexing for the medical missionaries at Mengo: it was popular and drew large numbers of patients; it was profitable, saving Mengo from economic collapse; but it also, in their estimation, at least had the potential to undermine their evangelical efforts. Overall, the result of the advent of arsenic injections was that discerning Africans acknowledged biomedicine’s ability to heal, even if they did not understand it in biomedical terms. In other words, “606” popularized biomedical practice, in a way that mercury treatment could not, but also not in a way that reinforced the missionaries’ ideas.

### **Circumcision**

Male circumcision was also used at Mengo Hospital, and it also was vexing to the missionaries. Although Cook used circumcision to treat phimosis, the syphilis complication that prevents the foreskin from retracting, between the 1850’s and the 1930’s, this procedure

<sup>72</sup> J.H. Cook to A.R. Cook May 8, 1925, Incoming Correspondence from CMS, 1919-1932; M. W. Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 221.

<sup>73</sup> “Mengo Hospital Accounts, Oct. 1921-1928,” ACML; M. W. Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 221.

was widely believed to reduce the risk of syphilis infection.<sup>74</sup> While Tuck points out that the Baganda had no tradition of male circumcision and, therefore, might have been inclined to view it as emasculating, colonial officials stated that Baganda thought “circumcision is a complete remedy [for syphilis].”<sup>75</sup>

Whether this perception of the Baganda view was correct is unclear, but colonial officials, and presumably missionaries too, ascribed to it, and sought to prevent recourse to circumcision for syphilis treatment. The Uganda Branch of the British Medical Association (UBBMA), of which Cook was a founding member, and the president three times, thus changed its fees for circumcision.<sup>76</sup> Although it normally charged Africans 3/-, Indians 7.5/-, and Europeans 10/- for circumcision, the allowed fees were doubled “if patient suffering from venereal disease.”<sup>77</sup> Additionally, Mengo staff required patients seeking circumcision to pay the fee in full before the operation, knowing that patients might have to leave Mengo to collect the fee, and hoping they would not return for the treatment.<sup>78</sup> Both since circumcision was an accepted prophylactic for syphilis, and it is difficult to imagine why patients would go to Mengo for male circumcision if not to treat a venereal condition, the UBBMA’s decision to double fees for venereal patients underlines how the missionary doctors sought to impart moral meaning through their treatments. Meanwhile, that African

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<sup>74</sup> V.E. Lloyd, and N.L. Lloyd, “Circumcision and Syphilis,” *The British Medical Journal* 1 (1934): 144-5; Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 916 Yosua Basajabalaba admitted May 4, 1915; Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 948 J.S.M. Byass admitted May 11, 1915; Mengo Hospital In-Patient case notes, 1921, Mengo Hospital Papers, ACML, 1901 Bulasiyo Mukasa admitted November 5, 1915.

<sup>75</sup> W.I. Webb, “Appendix VI: Copy of letter to S.M.O., Mengo Hospital, and M.O. Nsambya,” in *Annual Medical and Sanitary Report for the Year Ended 31<sup>st</sup> December, 1921*, ed. C.A. Wiggins (Entebbe: Government Printer, 1922), 78; M. W. Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 211.

<sup>76</sup> W.R. Billington, “Albert Cook 1870-1951: Uganda Pioneer,” *BMJ* 4, no. 5737 (December 19, 1970): 739.

<sup>77</sup> Uganda Branch of the British Medical Association, “Table 3” in *Schedule of fees for Medical Officers as approved by the council of the Uganda Branch of the British Medical Association* (February 7, 1920).

<sup>78</sup> M. W. Tuck, “Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda” (PhD diss., Northwestern University, 1997), 223.

patients nevertheless sought circumcision also confirms that the European doctors at Mengo did not “control” the therapeutic conversation with patients.

## **Europeans**

How did European venereal treatment differ from that given to Baganda patients? European patients received the same treatments, though as we have already seen, they were charged higher patient fees. Christopher J. Graham, when a patient at Mengo, told Cook that in 1918 he had received two intravenous injections of mercury and took mercury pills (irregularly) for a year. Graham also reported having a total of 9 “606” injections. When he attended Mengo in 1921, he was again being treated for syphilis.<sup>79</sup> J.S.M. Byass, a European syphilis patient at Mengo in 1915, developed phimosis, and was circumcised to relieve it on May 12 at 10 AM.<sup>80</sup>

As opposed to African patients, however, these patients, both members of the Church of England, though perhaps the focus of moral contempt, were not subjected to evangelical efforts. As was shown in previous chapters, these patients still enjoyed comparatively luxurious accommodations and comforts, such as tea on the lawns, and their “moral lapses” were treated with discretion, not publicized as such. In the end, however, the most significant difference between the Baganda experience of venereal treatment and that of Europeans may have been its segregated nature, as Europeans were treated exclusively by white doctors and nurses and housed in separate facilities.

## **Conclusion**

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<sup>79</sup> Mengo Hospital In-Patient case notes, 1A 1921, Mengo Hospital Papers, ACML, 32 Christopher J. Graham admitted March 7, 1921.

<sup>80</sup> Mengo Hospital In-Patient case notes, 1915, Mengo Hospital Papers, ACML, 948 J.S.M. Byass admitted May 11, 1915.

What work did biomedical treatment do at Mengo Hospital? In some ways, it actually inhibited adoption of both the Western biomedical hegemony and missionary ideology, since the experience of treatment at Mengo Hospital compromised the effectiveness of evangelical efforts. The mercury treatments were painful and dangerous and were rejected and refused, while “606” and circumcision undercut missionary messages about syphilis as a moral disease. Missionary preferences for mercury treatment that served evangelical goals as well as their distaste for treatments that undercut their moral message are reflected in the fees charged for those treatments. However, making “606” expensive also made Mengo Hospital financially dependant on a treatment plan that diluted moralizing rhetoric. The response of Africans to these different forms of biomedical treatment show how they made meaning of biomedicine and selectively appropriated those elements of biomedical treatment that made sense to them.

## CHAPTER FOUR: TRAINING

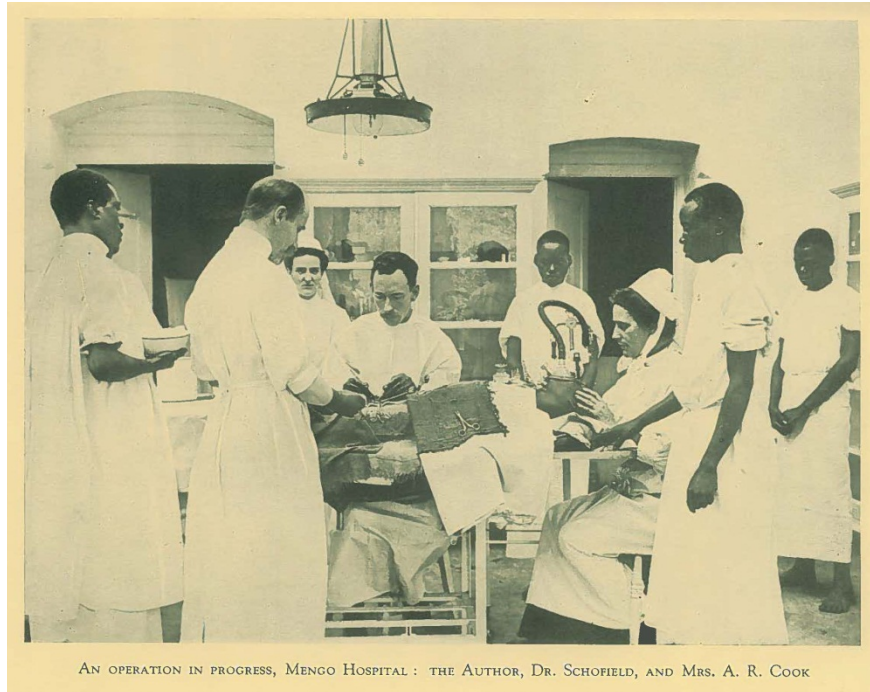


Image 10: “Native” Medical Assistants Helping Perform an Operation<sup>1</sup>

As mentioned above, an African, possibly a Muganda, may well have administered Lulyatumanyi’s mercury injections. Scholars have generally given short shrift to the role of the syphilis epidemic in developing the biomedical profession in Uganda, though John Iliffe does note that George Keane looked to Mengo Hospital’s use of “native” medical assistants when he decided to start a Medical School.<sup>2</sup> In this chapter, I show that concerns about venereal disease and its effect on maternity in the early twentieth century were intimately tied to creation of biomedical schools and training centers for the Baganda.

### “Native Boys,” Midwives, and Doctors

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<sup>1</sup> “An Operation in Progress, Mengo Hospital: The Author, Dr. Schofeild, and Mrs. A.R.Cook” in *Uganda Memories 1897-1940* by A.R. Cook (Kampala: The Uganda Society, 1945), 248.

<sup>2</sup> See Introduction, p. 11.



As discussed in the preceding chapter, the availability of Salvarsan and circumcision popularized biomedicine for the treatment of illness, and thereby advanced its acceptance. However, anti-venereal work was also significant in the history of biomedicine in Uganda the involving Ugandan subaltern figures in the administration of treatment, and thereby training and establishing a cadre of Ugandan biomedical practitioners. The Cooks began training “dispensary boys” as early as 1899. Initially, practical considerations motivated such training. In 1911, the CMS medical subconference, for example, pointed out that while ideally 440 nurses would support the 88 doctors in the group, there were only 54 nurses working at the CMS.<sup>3</sup>

Recruiting and training Baganda students in biomedicine, however, was difficult. As Cook confessed, “training the native assistants has been long and arduous, and after ten years we can only point to four thoroughly trustworthy male native assistants.”<sup>4</sup> Cook noted considerable reluctance among potential pupils, who felt that working in Western medicine was “nasty work and might be dangerous.”<sup>5</sup> Thus, while Cook had six “dispensary boys” in 1899, “only one or two were fairly smart and appeared to take real interest in their work.”<sup>6</sup>

Although pursuing a Western medical profession remained unpopular among the Baganda, CMS efforts to induce “native assistants” to pursue the unpopular work intensified in response to the syphilis epidemic. In 1919, in an article reflecting on the threat venereal disease posed to the supply of labor in Uganda, Ernest Cook, Albert Cook’s nephew, argued that “there must be a systematic medical training for suitable native boys on a large

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<sup>3</sup> Minutes, April 7, 1911, “Medical Subconference Meeting Minutes,” 1908-1935 (A.R. Cook Secretary), ACML.

<sup>4</sup> W.D. Foster, “Dr Albert Cook and the Early Days of the Church Missionary Society’s Medical Mission to Uganda,” *Med. Hist* 12, no. 4 (October, 1968): 341.

<sup>5</sup> *Ibid.*

<sup>6</sup> W.D. Foster, “Makerere Medical School: 50<sup>th</sup> Anniversary,” *BMJ* no.3 (1974): 675.

scale....Trained Native Assistants are needed in every *Saza* in the country, a dispensary attached to every *Gombolola* where at least venereal disease can be treated.”<sup>7</sup> Just two years earlier, in 1917, Mengo had officially established a medical school for “natives,” with an initial enrollment of 17 students. Again in 1921, Ernest Cook sought to involve Africans in syphilis treatment: “Thousands of Native youngsters are suffering from Congenital Syphilis who could easily be treated if it were recognized, and here is where our Native trained Assistant comes in again.”<sup>8</sup> In 1924, Keane, then in charge of the Protectorate’s anti-venereal campaign, heeded this advice, moving the medical school from Mengo to Mulago Hospital, where it grew with the hospital, which was eventually transformed from a small venereal dispensary to the national referral hospital in Uganda.<sup>9</sup>

Meanwhile, as part of their efforts against venereal disease, the Cooks established a school at Mengo to train “native midwives,” East Africa’s first. In 1918, fundraising for the maternity school, the Cooks explained that it would fill a gap in the government’s anti-venereal efforts: “A weak point in the Government scheme has been that the impact of the effort has been necessarily chiefly directed towards the male population, and that owing to the number of venereal centres being few, the area of the Protectorate influenced has been limited.”<sup>10</sup> The proposed Lady Coryndon Maternity Training School (LCMTS) would train young women in midwifery and the treatment of venereal disease; these midwives would

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<sup>7</sup> E.N. Cook, “A Native Medical Service for Uganda,” *The Uganda Herald*, June 6, 1919.

<sup>8</sup> E.N. Cook, “Medical Inspections in Schools,” *The Uganda Herald*, June 10, 1921.

<sup>9</sup> W.D. Foster, “Dr Albert Cook and the Early Days of the Church Missionary Society’s Medical Mission to Uganda,” *Med. Hist* 12, no. 4 (October, 1968): 341.

<sup>10</sup> A.R. Cook and K.T.Cook, “The Population Problem in the Uganda Protectorate,” *The Uganda Herald*, December 13, 1918.

then take the anti-venereal campaign “to the people’s homes, to save the lives of mothers and infants.”<sup>11</sup> As discussed in a previous chapter, the school opened in 1921.

The CMS praised Katharine Cook’s vision in training midwives and referred to its influence in the region:

By her wisdom and foresight, she was the first to initiate the great Welfare Work, which resulted in the foundation of the Lady Coryndon MTS and has since led to the development of similar activities in several other parts of Africa, and been of important service to the Empire.<sup>12</sup>

Nevertheless, the “trained natives” faced considerable obstructions, and their impact on both syphilis and maternal health should not be overstated. Midwives were not always well received in the communities where they were placed. Writing to Katharine Cook in 1920 from a CMS maternity center in Mbarara, Ankole, Isabel Sewin, a fellow medical missionary, reported: “The people seem afraid of them [the midwives].....So far, the Maternity work is not a success—only one case up to date.”<sup>13</sup> Moreover, Mengo Hospital only managed to train a select few pupils—who met the Cooks’ “moral” standards. According to Cook’s biographer, Foster, only 112 midwives passed the Uganda midwives’ certification examination; of those, 24 were later dismissed for “immorality,” and another 24 quit the profession to marry.<sup>14</sup> Likewise, in its seven years of operation, it is unlikely that the Mengo medical school trained many African doctors, with a “class” of only 17 per year.

Still, despite their small number, the Africans who were trained in response to the syphilis epidemic had an impact on the development of biomedicine in Uganda. A number

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<sup>11</sup> Canon A.M. Williams, “Fifty Years in the Service of Suffering: Mengo Hospital Celebrates its Jubilee,” *CMS Outlook* no. 83 (May, 1947).

<sup>12</sup> Minutes, June 24, 1924, “Extract from the Minutes of the Medical Committee at Salisbury Square,” Incoming General Correspondence, 1919-21; 1925-1930; 1917-1931. ACML.

<sup>13</sup> Isabel Sewin to Katharine Cook, August 12, 1920, Incoming General Correspondence, 1919-21; 1925-1930; 1917-1931. ACML.

<sup>14</sup> W.D. Foster, “Dr Albert Cook and the Early Days of the Church Missionary Society’s Medical Mission to Uganda,” *Med. Hist* 12, no. 4 (October, 1968): 342.

of the students trained at Mengo were from influential families. The CMS insisted that prospective medical, and midwife students all read and write English, and, subsequently most students were drawn from King's College Budo, founded by missionaries in 1906 to educate the sons of chiefs.<sup>15</sup> Thus the children of Buganda's most powerful families passed through the Mengo training schools. Albert Cook noted with pride in his memoir that "Susana Nansikombi, the daughter of the Katikiro, Sir Apolo Kagwa," graduated with the top score of 78% among the first class of midwives.<sup>16</sup> These medical trainees, therefore, were in part comprised of Uganda's new elite.

Moreover, whatever their numbers and their background, Africans educated in Western biomedicine at Mengo Hospital were among the first Africans administering biomedical care to other Africans, and much of their work was directed towards treating venereal disease. For example, in 1902, one of Cook's six original "dispensary boys," Yusufu Musajawaza, became the first African in Uganda to perform a biomedical surgery: a circumcision. Cook swelled with pride, declaring that it was a "red letter day" and that Musajawaza had completed the operation "quite satisfactorily."<sup>17</sup> In the same vein, the Mengo medical school student syllabus included:

instruction in sterilization of syringes & instruments used in venereal work. Intramuscular injections of Hg. [mercury] cream & Arseno-benzol preparations [Salvarsan, etc.]. Preparation of apparatus & patient for intravenous injections. Mercury in syphilis: its use & dangers. Irrigation in gonorrhoea.<sup>18</sup>

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<sup>15</sup> Minutes, December 9, 1908, "Medical Subconference Meeting Minutes," 1908-1935 (A.R. Cook Secretary), ACML; Gordon P. McGregor, *King's College Budo: The First Sixty Years* (Nairobi: Oxford University Press, 1967).

<sup>16</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 330.

<sup>17</sup> *Ibid*, 675.

<sup>18</sup> "Mengo Medical School: Syllabus of Training." ACML.

These African medical students, therefore, were well qualified to administer European biomedical anti-venereal care.

Most significantly, though few in number, the African medical practitioners at Mengo Hospital treated Africans for the diseases that Vaughan has argued were used to pathologize African sexuality and emphasize the difference between Africans and Europeans.

Notwithstanding this baggage, these medical professionals, in the words of the Archdeacon of Uganda, Canon A.M. Williams, “proved to the world that the African woman is as capable at these responsibilities as her sister in Europe or elsewhere.”<sup>19</sup> Perhaps this is the most important legacy of Mengo’s evangelization, and of its role in the syphilis epidemic.

It is also a legacy that had an impact in Baganda society beyond those few students, as these African biomedical doctors also shared their knowledge with the Baganda. In 1920, J.M. Mukasa wrote in the Protestant newspaper, *Ebifa mu Buganda*: “*Banange, Nsanyuse okubategeza ku bulwade buno obunene obwa Kabotongo*. [Friends, it is my pleasure to inform you about a very important disease called syphilis.]”<sup>20</sup> Though it is perhaps over-reaching to attribute the cause directly to African practitioners, by 1929, Baganda’s intellectuals had incorporated biomedicine into their discourse on solutions to the syphilis epidemic. In that year, the *Ebifa mu Buganda* featured a debate between Yokana Walusimbi and Musomi Wa Mawulire Owa, two members of Buganda’s intellectual elite, about syphilis and the crisis of the falling birthrate. Tellingly, both parties in the debate assigned an important role to biomedicine in addressing venereal disease.

Owa, writing in November, 1929, called for coercive biomedical ordinances:

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<sup>19</sup> Canon A.M. Williams, “Fifty Years in the Service of Suffering: Mengo Hospital Celebrates its Jubilee,” *CMS Outlook* no. 83 (May, 1947).

<sup>20</sup> J.M. Mukasa, “Mengo Medical School: Syphilis=Kabotongo,” *Ebifa mu Buganda*, trans. Robinson Kisaka (1920).

*Buli muwala yena nga ayogerezebwa abo abazade bo muwala, bamalenga okusaba omuku oyo ebaluwa yo musawo dala Omuzungu etegeza nga omusaja oyo talwalanga ku kabotongo na nziku*

[The parents of a girl, who is still in courtship, should ask the potential husband for a medical report from a white doctor showing that he is free from syphilis and gonorrhoea.]<sup>21</sup>

Thus white doctors and European medical technique had attained sufficient currency among some Baganda elites that biomedical examinations and certificates could be integrated into processes of social reproduction.

Owa also advocated quarantining venereal disease patients on an island in Lake Victoria, as the British had earlier quarantined Sleeping Sickness victims. In Owa's vision, the British Government would provide biomedical facilities:

*Era Gavumenti Engereza esabibwe, ezimbeko Edwaliro edene erye nziku ne kabotongo.*

[Let the British Government build a hospital there for treating gonorrhoea and syphilis.]<sup>22</sup>

In response, Yokana K.S.B. Walusimbi argued in December 1929 that eliminating syphilis required a combination of moral revival and biomedicine. He encouraged those suffering from syphilis to seek:

*Ekanisa ne Yekereziya ne Mizigiti, Bwe weyuna omwo n'olyoka odamu endasi munda okulwanyisa omulabe w'emyoyo ne mirbiri oyo wandwa-de.*

[Churches, (both Protestant and Catholic) and mosques, for when you take refuge there, you gain new energy to fight disease, the enemy of body and soul.]<sup>23</sup>

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<sup>21</sup> Musomi Wa Mawulire Owa, "Okugoba Kabotongo ne Nziku" *Ebifa mu Buganda* trans. Robinson Kisaka (November, 1929).

<sup>22</sup> Musomi Wa Mawulire Owa, "Okugoba Kabotongo ne Nziku" *Ebifa mu Buganda* trans. Robinson Kisaka (November, 1929).

<sup>23</sup> Yokana K.S.B. Walusimbi, "Okugoba Kabotongo n'Enziku" *Ebifa mu Buganda* trans. Robinson Kisaka (December, 1929).

Walusimbi's prescription mirrors Cook's interpretation of the syphilis epidemic as a matter of morality; but unlike Cook, he invokes a variety of religious institutions—including Islam—to provide moral guidance and strength to fight syphilis. Walusimbi thus modifies Cook's specific Protestant evangelical message into a general charge to rely on faith as a safe-guard against disease. This approach synthesizes Cook's evangelical model with "traditional" Ganda healing cosmologies that conceptualized diseases as interactions between this world and the supernatural. At the same time, Walusimbi also incorporated biomedical solutions into his argument. He mentions that for those who have already fallen ill: "*Amalwaliro ge Mulago gali wo-na mu Buganda oku-dukiramu* [Mulago has medical dispensaries all over Buganda.]"<sup>24</sup> Accordingly, in response to the syphilis outbreak, secular biomedicine, as interpreted through a Ganda lens, emerged in the discourse of Baganda's intellectual elite as an important part in the fight against venereal disease.

## **Conclusion**

Intriguingly, and somewhat poignantly, although the CMS sponsored *Ebifa mu Buganda*, Mengo Hospital was not mentioned in the 1929 discussion in response to the syphilis epidemic, even though during the First World War, and shortly thereafter, Mengo Hospital almost single-handedly provided biomedical care for venereal disease in Uganda. In part, no doubt, this reflects the British government's increased investment in Uganda's healthcare through the 1920s; but it also indicates how Mengo's evangelizing effort—to convert and to "save" morally—was transformed or "translated" into a "Ugandan" version, even among Protestant Baganda intellectuals, in the development and acceptance of biomedical practice in Uganda.

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<sup>24</sup> Yokana K.S.B. Walusimbi, "Okugoba Kabotongo n'Enziku" *Ebifa mu Buganda* trans. Robinson Kisaka (December, 1929).

## CONCLUSION

This thesis has examined the experience and significance of syphilis treatment at the major evangelical mission hospital in colonial Uganda, Mengo Hospital, during the 1910s and 1920s. Considering whether medical missionaries attempted to colonize consciousness, I demonstrated that they simultaneously aimed to cure bodies and to save souls, but also that Baganda reacted to these efforts by negotiating, refusing, walking away from, and, ultimately determining the meaning of such treatment through a Ganda perspective.

Examining missionary motives for treating syphilis entailed using novel sources, especially the contents of printed patient case note sheets. Detailing the history of the construction of hospital buildings demonstrated that Albert and Katharine Timpson Cook, the doctor and nurse, husband and wife team, designed clinical care at Mengo Hospital to incorporate moral instruction, religious healing, and a European “civilizing mission” with biomedical care. The Cooks, we have seen, promoted and devoted attention to the notion of a syphilis epidemic because such a notion accorded with their evangelical goals, allowing them to treat syphilis as a moral failure and missionary opportunity as much as a medical fact.

Baganda patients, kin and society at large, however, exhibited ambivalence towards biomedicine. Biomedical conceptions of syphilis conflicted with Ganda notions about the more extensive illness category, known as *kabotongo*, as well as with vernacular perceptions of venereal disease as a mark of distinction, and even fundamental understandings of the nature of illness. Additionally, kin therapy management group decisions about whether or not and how to provide biomedical care for a sick relative, as well as Ganda discourse about female mobility and syphilis treatment, show that receiving care at Mengo Hospital provoked



questions about British official and missionary involvement in intimate health concerns and social reproduction.

Despite these ambiguities, many Baganda patients entered into this evangelical, “civilizing” medical mission. Medical treatment at the clinic involved a negotiation between patients (and kin) and the hospital staff in which Mengo Hospital’s evangelical work could often be quite limited (though the evidence is less obvious here). Baganda patients reacted to painful and dangerous mercury treatments with refusal, disobedience, and simply “running away,” while in the face of the seemingly more efficacious Salvarsan or “606” injections, they stepped forward, paid the necessary fees, and tin effect clamored for the arsenical treatment. Ultimately, the biggest impact of syphilis treatment at Mengo Hospital was not that it supported moral change or conversion to Christianity, but it resulted in selective acceptance, even eagerness, for biomedical care.

In addition to popularizing biomedical treatments, anti-venereal efforts at Mengo also promoted the creation of a Ugandan biomedical profession. The desire for Ugandan medical assistants to persuade “natives” to undergo treatment, administer injections, and bring biomedical treatment into rural Uganda spurred the Cooks to train “natives” into assistants, doctors, and midwives. This new professional cadre then encouraged the acceptance of biomedical practices among the emerging Baganda elite.

This analysis contrasts with earlier work focusing on disease in Africa and syphilis in Uganda as a social construction that pathologized Africans. Megan Vaughan argued that colonial medical discourses had two aims:

Firstly, it could be used to pathologize the African as a social being, and to represent difference in such a way as would provide a clear rationale for domination to those who wished to find it. Secondly, it was able to satisfy the

liberal conscious by feeding on a partly secularized Christian ideology which represented anything “medical” as an act of benevolence, and even salvation.<sup>1</sup>

From a European prospective, of course, Vaughan is quite correct. For Col. Lambkin and other colonial officials, stories of rampant syphilis, whole “tribes” covered in loathsome sores, mothers suffering from strings of syphilitic miscarriages, or, the need to inoculate healthy looking newborns since syphilis’ pervasiveness made contracting the disease seem inevitable, all of this did construct a picture of unrestrained and diseased African sexuality. In response, Albert and Katharine Timpson Cook, saw the treatment of syphilis as an act of Christian charity—that also presented an opportunity for Christian salvation. As Chapter One showed, the Cooks viewed their hospital as a harbor for “human wreckage,” “heathens” with festering sores, and a temple to relieve “the mass of sheer human misery” of both body and mind.<sup>2</sup> This doctor and nurse team strove to infuse the care provided, even interactions between doctors and patients, with their evangelical mission of saving not just bodies, but souls.

Yet in her arguments on syphilis in Uganda, Vaughan seems to have missed the significance of the syphilis epidemic to the development of biomedicine in Uganda. Her analysis underestimates what occurred at Mengo, giving the impression that the missionary hospital was simply a site for conceptualizing disease, rather than a place to diagnose and to treat it. As Chapter Two demonstrated, Baganda displayed ambivalence, refusal, and disobedience at least as often as they complied with and appropriated aspects of biomedical care in this evangelical hospital. Kin negotiated their family members’ care, seeking biomedical treatment on their own terms, and Baganda society engaged in its unique

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<sup>1</sup> Megan Vaughan, “Health and hegemony: representation of disease and the creation of the colonial subject in Nyasaland,” in *Contesting Colonial Hegemony: State and Society in Africa and India* eds. Dagmar Engels and Shula Marks (London: British Academic Press, 1994), 173-4.

<sup>2</sup> A.R. Cook, *Uganda Memories, 1897-1940* (Kampala: The Uganda Society, 1945), 274.

discourse on the syphilis epidemic, one that at its core was a dispute over colonial indirect rule and foreign intervention.

As shown in Chapter Three, in the clinic itself, the Baganda became participants in biomedical practice. They interacted with and evaluated biomedicine, appropriating some bits, rejecting and refusing others, all the while constructing their own meaning for it. Chapter Four shows how some Baganda also learned how to practice biomedicine, to give injections and perform circumcisions, and in the process initiated the beginnings of biomedical education in Uganda.

Nonetheless, looking in 2012 from Ann Arbor, Michigan toward the country of Uganda, a country most recently known for AIDS and its depiction in a social media film about child abduction and the Lord's Resistance Army, "KONY 2012," it appears that Vaughan's description of external pathologization of Uganda can still hold sway over American and European imaginations. This thesis, however, shows that Baganda were not simply the objects of either any collective Western imagination, or of very particular British colonial and missionary aims and desires, but rather have long been participants in producing, adopting to their circumstances, and using biomedical knowledge.

## BIBLIOGRAPHY

### Archival/Manuscript Collections

Albert R. Cook Medical Library, Kampala, Uganda  
Mengo Hospital Papers, 1898-1944

### Newspapers and Periodicals

*East African Standard, Mombasa Times, and Uganda Argus*; 1903-1915  
*The Uganda Herald*; 1912-1922

### Films

*Le grand blanc de Lamaréné (2005)*. DVD. Directed by Bassek Ba Kobhio. San Francisco: California Newsreel, 2005.

### Printed Primary Sources

- “Aba-Malaki.” *Ebifa mu Buganda*, August, 1929.
- Alisat, Mugoya. Interview by author. Wakiso, June 28, 2011.
- A.M.B.K. “Okubulira Okukulu Okwa Dr. A.R. Cook. C.M.S. Kikoma Buwekula,” *Ebifa mu Buganda*, April, 1921.
- Billington, W.R. “Albert Cook 1870-1951: Uganda Pioneer,” *BMJ* 4, no. 5737 (December 19, 1970): 738-740.
- Billington, W.R. “Interpersonal Relationships in Medicine.” Lecture, Albert Cook Memorial, Kampala, Uganda, 1965.
- Chwa, Daudi. “Eteka Lyo Bwenzi.” *Ebifa mu Buganda*, July, 1918.
- Coats, Joseph. *A Manual of Pathology*, 5th ed. London: Longmans, Green and Co., 1903.
- Cook, A.R. *A Doctor and His Dog in Uganda*. Edited by H.B. Cook. London: The Religious Tract Society
- Cook, A.R. *A Medical Vocabulary and Phrase Book in Luganda*. Kampala, Uganda & London: Uganda Book Shop & Society for Promoting Christian Values, 1921.
- Cook, A.R. “A Social Purity Campaign,” *Mercy and Truth* 25 (1921).
- Cook, A.R. “Syphilis in Uganda.” *The Lancet*, December 12, 1908.
- Cook, A.R. “The Treatment of Ante-Natal Syphilis in Buganda Women” Lecture, UBBMA, March 22, 1929.
- Cook, A.R. *Uganda Memories, 1897-1940*. Kampala: The Uganda Society, 1945.
- Cook, J.H. *Okufa Okwabana Mu Buganda Bwekuli*. Translated by Robinson Kisaka. Entebbe Uganda: Government Printer, 1908.
- Franklin, E.C. *A Manual of Venereal Disease: Being a Condensed Description of those Afflictions and Their Homoeopathic Treatment*. Chicago: Gross & Delbridge, 1883.

- Gow, William J. "Syphilis in Obstetrics." In *A System of Syphilis* edited by D'Arcy Power and J. Keogh Murphy. London: Oxford University Press, 1908.
- Kagwa, Apolo, Stanistas Mugwanya and Z.Kizito Kisingiri. "Etteka Ku Ndwade Embi Ezikwata." *Muno*, September, 1913.
- Kagwa, Apolo. *The Customs of the Baganda*. Translated by Ernest Kalibala. New York: Columbia University Press, 1934.
- Kekwangire, Jack. Interview by author. Wakiso, June 28 2011.
- Kiwumulo, Joshua. Interview by author. Wakiso, June 28, 2011.
- Lambkin, F.J. "The Treatment of Syphilis." In *A System of Syphilis*, edited by D'arcy Power, 253-356. London: Oxford University Press, 1908.
- Lugard, Fredrick John Dealtry. *The Rise of Our East Africa Empire Early Efforts in Nyasaland and Uganda*. Edinburgh and London: W. Blackwood and Sons, 1893
- "Mengo Hospital Accounts, Oct. 1921-1928," ACML.
- Mukasa, Temusewo B. "Bamalaya Abaganda eNairobi." *Ebifa mu Buganda*, July, 1918.
- Mutebe, Julius. Interview by author. Wakiso, June 28, 2011.
- Namusoke, Fatuma. Interview by author. Mulago Hospital, Kampala, June 12, 2011.
- Owa, Musomi Wa Mawulire. "Okugoba Kabotongo ne Nziku." *Ebifa mu Buganda*, November, 1929.
- Power, D'Arcy. "Surgey of Syphilis" in *A System of Syphilis*, edited by D'Arcy Power and J. Keogh Murphy, 1-241. London: Oxford University Press, 1908.
- Remondino, P.C. *History of Circumcision, from the Earliest Times to The Present. Moral and Physical Reasons for its Performance*, Philadelphia and London: The F.A. Davis Co., 1891.
- Secretary of State to the Colonies. Report of the East Africa Commission. 1925 Cmd. 2387.
- "The Irony of the Comparison." *The East African Standard*, February 22, 1908.
- Trowell, H.C. "Albert Cook Memorial Lecture, 1956: The Medical Pioneers and Explorers of East Africa" *The East African Journal* 4, no. 8 (August 3, 1957): 429.
- Tucker, Alfred R. "Syphilis in Uganda." *The Lancet*, October 24, 1908.
- Uganda Branch of the British Medical Association, "Table 3" *Schedule of fees for Medical Officers*. Uganda Branch of the British Medical Association, February 7, 1920.
- Uganda Protectorate (1909), *Annual Medical and Sanitary Report for 1908*, Entebbe.
- Uganda Protectorate (1913), *Annual Medical and Sanitary Report for 1912*, Entebbe.
- Uganda Protectorate (1914), *Annual Medical and Sanitary Report for 1913*, Entebbe.
- Uganda Protectorate (1915), *Annual Medical and Sanitary Report for 1914*, Entebbe.
- Uganda Protectorate (1916), *Annual Medical and Sanitary Report for 1915*, Entebbe.
- Uganda Protectorate (1917), *Annual Medical and Sanitary Report for 1916*, Entebbe.
- Uganda Protectorate (1918), *Annual Medical and Sanitary Report for 1917*, Entebbe.
- Uganda Protectorate (1919), *Annual Medical and Sanitary Report for 1918*, Entebbe.
- Uganda Protectorate (1920), *Annual Medical and Sanitary Report for 1919*, Entebbe.
- Uganda Protectorate (1921), *Annual Medical and Sanitary Report for 1920*, Entebbe.
- Uganda Protectorate (1922), *Annual Medical and Sanitary Report for 1921*, Entebbe.
- Uganda Protectorate (1923), *Annual Medical and Sanitary Report for 1922*, Entebbe.
- Uganda Protectorate (1924), *Annual Medical and Sanitary Report for 1923*, Entebbe.
- Uganda Protectorate (1925), *Annual Medical and Sanitary Report for 1924*, Entebbe.
- Uganda Protectorate (1926), *Annual Medical and Sanitary Report for 1925*, Entebbe.
- Uganda Protectorate (1927), *Annual Medical and Sanitary Report for 1926*, Entebbe.

Uganda Protectorate (1928), *Annual Medical and Sanitary Report for 1927*, Entebbe.  
 Uganda Protectorate (1929), *Annual Medical and Sanitary Report for 1928*, Entebbe.  
 Uganda Protectorate (1930), *Annual Medical and Sanitary Report for 1929*, Entebbe.  
 Walusimbi, Yokana K.S.B. "Okugoba Kabotongo n'Enziku." *Ebifa mu Buganda*, December, 1929.  
 Williams, Canon A.M. "Fifty Years in the Service of Suffering: Mengo Hospital Celebrates its Jubilee." *CMS Outlook* no. 83 (May, 1947).

## Secondary Sources

- Aktins, Kelesto E. *The Moon is Dead! Give Us Our Money!: The Cultural Origins of an African Work Ethic, Natal, South Africa, 1843-1900*. Portsmouth, NH: Heinemann, 1993.
- Baronov, David. *The African Transformation of Western Medicine and the Dynamics of Global Cultural Exchange*. Philadelphia, PA: Temple University Press, 2008.
- Brehmer-Andersson, Eva *Dermatopathology*. Verlag: Springerlink, 2006.
- Brothwell, Don R. "VIII.157:Yaws." In *The Cambridge World History of Human Disease* Vol. 1, edited by Kenneth F. Kiple, 1096-1100. Cambridge University Press, 1993.
- Callahan, Bryan. "'Veni, VD, Vici'?: Reassessing the Ila Syphilis Epidemic." *Journal of Southern African Studies* 23, no. 3 (September, 1997): 421-440.
- Carpenter, Mary Wilson. *Health Medicine, and Society in Victorian England*. Westport, CT: Praeger, 2010.
- Centers for Disease Control and Prevention. "Sexually Transmitted Diseases (STDs): Syphilis – CDC Fact Sheet," Centers for Disease Control and Prevention: CDC 24/7 Saving Lives. Protecting People. Saving Money through Prevention, <http://www.cdc.gov/std/syphilis/stdfact-syphilis.htm> (accessed March 13, 2012).
- Comaroff, Jean and John L. Comaroff. "The Colonization of Consciousness in South Africa." *Economy and Society* 18, no. 3 (August, 1989): 267-296.
- Comaroff, Jean and John L. Comaroff. *Of Revelation and Revolution*, Vol. 1, *Christianity, Colonialism, and Consciousness in South Africa*. Chicago: University of Chicago Press, 1991.
- Dirar, Uoldelul Chelati. "Curing Bodies to Rescue Souls: Health in Capuchin's Missionary Strategy in Eritrea." In *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, edited by David Hardiman, 251-280. Amsterdam: Rodopi, 2006.
- Davies, J.N.P. "The History of Syphilis in Uganda," *Bulletin of the World Health Organization* 15 (1956): 1041-55.
- Epstein, Helen. *The Invisible Cure: Why we are losing the fight against AIDS in Africa*. New York: Picador, 2007.
- Fanon, Frantz. *A Dying Colonialism*. Translated by Haakan Chavalier. New York: Monthly Review Press, 1965.
- Feierman, Steven. *Peasant Intellectuals: Anthropology and History in Tanzania*. Madison: The University of Wisconsin Press, 1990.
- Feierman, Steven. "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no.2/3 (June-September, 1985): 73-147.

- Foster, W.D. "Makerere Medical School: 50th Anniversary," *BMJ* no.3 (1974): 675-678.
- Foucault, Michel. *The Birth of the Clinic: Archaeology of Medical Perception*. Translated by A.M. Sheridan Smith. New York: Vintage Books, 1973.
- Goodchild, R.T.S. "A Medical Jubilee in Central Africa." *BMJ* 2, no. 4521 (August 30, 1947): 342-344.
- Hanson, Holly Elizabeth. *Landed Obligation: The Practice of Power in Buganda*. Portsmouth, NH: Heinemann Books, 2003.
- Hardiman, David. Introduction to *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*. Amsterdam Rodopi, 2006.
- Headrick, Rita. *Colonialism, Health, and Illness in French Equatorial Africa 1885-1935*. Atlanta: African Studies Association Press, 1994.
- Hunter, Mark. "Cultural Politics and Masculinities: Multiple-partners in Historical Perspective in KwaZulu-Natal." *Culture, Health & Sexuality* 7 (2005): 209-23.
- Hunt, Nancy Rose. *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo*. Durham, NC: Duke University Press, 1999.
- Hunt, Nancy Rose. "'Era of Force' 2: Concept Work, More Examples of Violence, Refusal & Public Healing." Lecture, History 355, Ann Arbor, Michigan, February 2, 2012.
- Hunt, Nancy Rose. "'Le Bebe en Brousse': European Women African Birth Spacing and Colonial Intervention in Breast Feeding in Belgian Congo." *The International Journal of African Historical Studies* 21, no. 3 (1988): 401-432.
- Ilfie, John. *East Africa Doctors*. Cambridge University Press, 1998.
- Ilfie, John. *Honour in African History*. New York: University of Cambridge Press. 2005.
- Janzen, J. "Therapy Management: Concept, Reality, Process," *Medical Anthropology Quarterly* 1, no. 1 (March, 1987): 68-84.
- Janzen, J. *The Quest for Therapy in Lower Zaire*. Berkeley: University of California Press, 1978.
- Jones, Ben. *Beyond the State in Rural Uganda*. Edinburgh: Edinburgh University Press, 2008.
- Kalibala, Ernest Balintuma. "The Social Structure of the Baganda Tribe of East Africa" PhD diss., Harvard University, 1946.
- Karlström, Mikael. "Modernity and Its Aspirants: Moral Community and Developmental Eutopianism in Buganda." *Current Anthropology* (December, 2004), 595-619.
- Kodesh, Neil. *Beyond the Royal Gaze: Clanship and Public Healing in Buganda*. University of Virginia Press, 2010.
- Kuhanen, Jan. *Poverty, Health, and Reproduction in Early Colonial Uganda*. Joensuu, Finland: University of Joensuu/Faculty of Humanities, 2005.
- Langwick, Stacey. "Articulate(d) bodies: Traditional medicine in a Tanzanian hospital." *American Ethnologist* 35, no. 3 (2008): 428-439.
- Lambkin, F.J. "The Treatment of Syphilis." In *A System of Syphilis*, edited by D'arcy Power, 253-356. London: Oxford University Press, 1908.
- Lloyd, V.E. and N.L. Lloyd, "Circumcision and Syphilis." *BMJ* 1 (1934): 144-5.
- Lyons, Marynez. "Sexually transmitted diseases in the history of Uganda," *Genitourin Med* 70, (1994): 138-145.
- Lyons, Marynez. "From 'Death Camps' to Cordon Sanitaire: The Development of Sleeping Sickness Policy in the Uele District of the Belgian Congo, 1903-1914." *Journal of African History* 26, (1985): 69-91.

- McGregor, Gordon P. *King's College Budo: The First Sixty Years*. Nairobi: Oxford University Press, 1967.
- McGregor, T.B. J.G. Pike, and M.P. Leonard. "Pathologic and physiologic phimosis: approach to the phimotic foreskin." *Can Fam Physician* 53, no. 3 (March 2007): 445-8.
- Mol, Annemarie. *The Body Multiple: Ontology in Medical Practice*. Durham and London: Duke University Press, 2002.
- Mol, Annemarie and John Law. "Regions, Networks and Fluids Anaemia and Social Topology." *Social Studies of Science* 24 (1994): 641-71.
- Musisi, Nakanyike. "Morality as Identity: the Missionary Moral Agenda in Buganda, 1877-1945." *The Journal of Religious History* 23, no. 1 (February, 1999): 51-74.
- Musisi, Nakanyike. "The Politics of Perception of Perception as Politics? Colonial and Missionary Representations of Baganda Women, 1900-1945." In *Women in African colonial histories*, edited by Jean Allman, Susan Geiger, and Nakanyike Musisi, 95-115. Bloomington, IN: Indiana University Press, 2002.
- Neligan, J.N. and D. M. Reese. *Medicines, their Uses and Mode of Administration*. New York: Harper & Brothers, 1844.
- Orley, John. "Concepts of Infectious Disease amongst the rural Ganda- with special reference to yaws and syphilis." In *Nkanga: Special edition on Medicine and Social Sciences in East and West Africa*, edited by F.J. Bennett 60-6. Kampala: Makerere Institute of Social Research, 1973.
- Orley, John. "Indigenous Concepts of Disease and their Interactions with Scientific Medicine." In *Health in Tropical Africa during the Colonial Period*, edited by E.E. Saben-Clare, D.J. Bradley and K.K. Kirkwood, 127-37. Oxford, 1980.
- Parker, John and Richard Rathone. *African History: A Very Short Introduction*. Oxford: Oxford University Press, 2007.
- Reinhart Koselleck. *Futures Past: On the Semantics of Historical Time*. Translated by Keith Tribe. New York: Columbia University Press, 2004.
- Reynolds, Pamela. *Traditional Healers and Childhood in Zimbabwe*. Athens, OH: Ohio University Press, 1996.
- Roscoe, John. *The Baganda: An Account of Their Native Customs and Beliefs*
- Rowe, John A. "Eyewitness Accounts of Buganda History: The Memoirs of Ham Mukasa and his Generation." *Ethnohistory* 36, no. 1 (Winter, 1989): 61-71.
- Rowe, John A. "Revolution in Buganda 1856-1900," PhD diss., University of Wisconsin, 1966.
- Stoler, Anna Laura. *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense*. Princeton and Oxford: Princeton University Press, 2009.
- Summers, Carol. "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," *Signs* 16, no. 4 (Summer, 1991), 787-807
- Tuck, Michael William. "Syphilis, Sexuality, & Social Control: A History of Venereal Disease in Colonial Uganda" PhD diss., Northwestern University, 1997.
- Turshen, Meredith. *The Political Ecology of Disease in Tanzania*. New Brunswick, NJ: Rutgers University Press, 1984.
- "Uganda—Buganda." In "Uganda the Country and the People—Bantu tradition," *Face Music*, [http://www.face-music.ch/inform/poeple\\_ugandabantu\\_en.html](http://www.face-music.ch/inform/poeple_ugandabantu_en.html) by Sarah Ndagire. (accessed March 28, 2012).



- Vail, Leroy. "Ecology and History: the example of eastern Zambia." *Journal of Southern African Studies* 3, no. 3 (April, 1977) 129-155.
- Vaughan, Megan. *Curing their Ills: Colonial Power and African Illness*. Stanford University Press, 1991.
- Vaughan, Megan. "Health and hegemony: representation of disease and the creation of the colonial subject in Nyasaland." In *Contesting Colonial Hegemony: State and Society in Africa and India*, edited by Dagmar Engels and Shula Marks, 172-201. London: British Academic Press, 1994.
- Vaughan, Megan. "Syphilis in East and Central Africa." In *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, edited by Terence Ranger and Paul Slack, 269-302. Cambridge University Press, 1992.
- White, Luise. *Speaking with Vampires: Rumor and History in Colonial Africa*. Berkeley, Los Angeles, and London: University of California Press, 2000.
- White, Luise. "'They Could Make Their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda." *The American Historical Review* 100, no. 5 (December, 1995): 1379-1402.
- Whyte, Susan Reynolds. "Pharmaceuticals as Folk Medicine: Transformations in the Social Relations of Health Care in Uganda." *Culture, Medicine and Psychiatry* 16 (1992): 163-186.
- Zeller, Diane. "The Establishment of Western Medicine in Buganda." PhD diss., Columbia University, 1971.